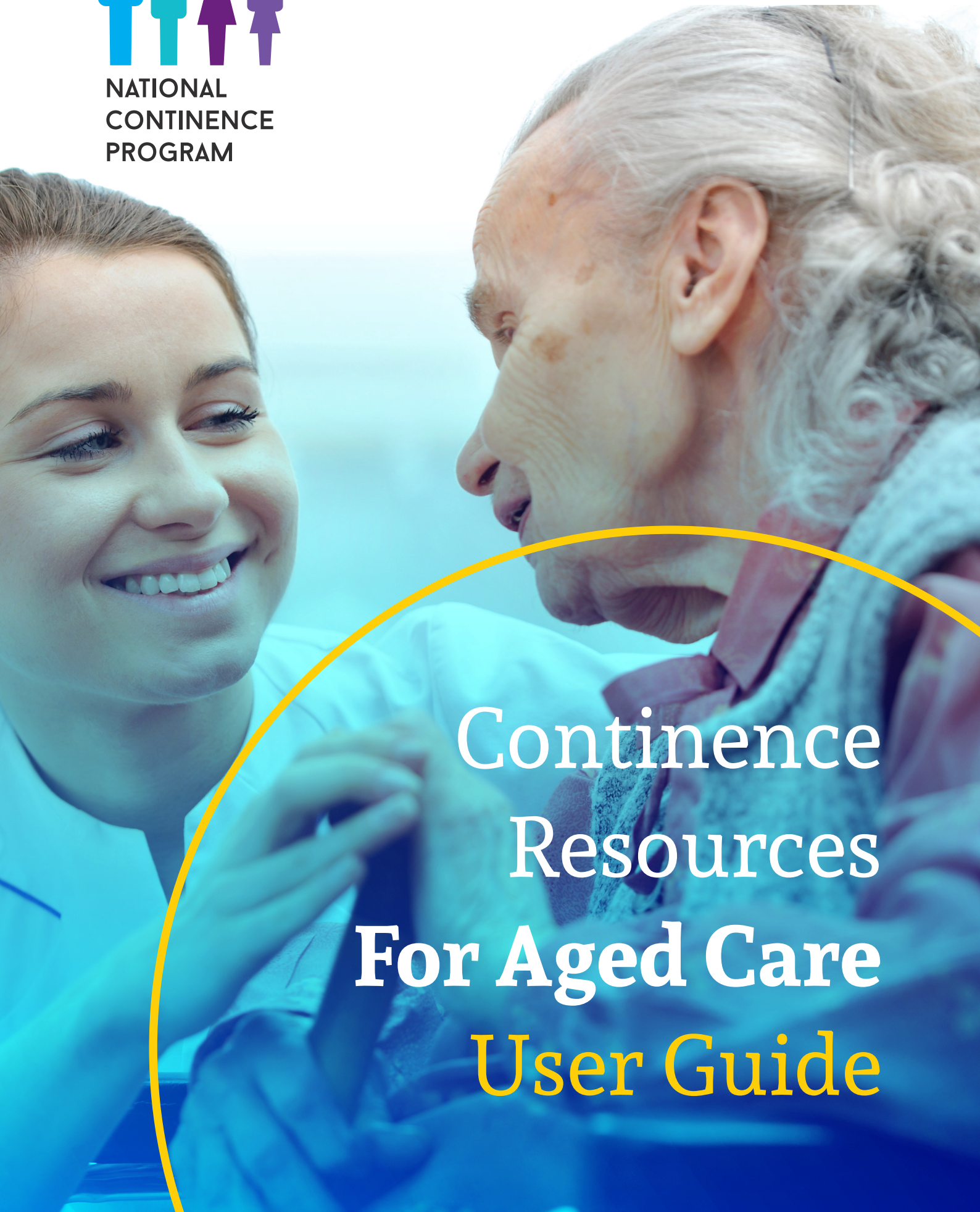
NATIONAL CONTINENCE PROGRAM



Continence Resources **For Aged Care** User Guide

“ The simple act of caring is heroic. ”

Edward Albert

Foreword

Continence Resources for Aged Care has been designed for use by health care professionals and personal care workers who care for older Australians in either residential aged care facilities or in the community.

Incontinence is a very personal condition and it can be embarrassing to discuss, even with a health professional or carer. Incontinence is not a normal part of ageing and older Australians who experience incontinence need to receive ongoing assessment, treatment and management to ensure they can live with dignity and feel respected.

The Aged Care Quality Standards (introduced in July 2019) underscore the importance of partnering with consumers to provide safe and effective continence care via ongoing assessment and planning that optimises their independence, health, well-being and quality of life.

A key consideration in the design of Continence Resources for Aged Care was to improve older Australians' access to comprehensive continence assessment that is evidence based and best practice.

This User Guide provides a detailed description of the forms and charts that make up the Continence Resources for Aged Care including assessment cues with accompanying rationale and care options.

The User Guide should be read in conjunction with the individual forms and charts which includes the following:

- Continence Screening Form
- Three-Day Bladder Chart
- Seven-Day Bowel Chart
- Monthly Bowel Chart
- Continence Assessment Form and Care Plan
- Continence Care Summary

The *Continence Resources for Aged Care* can help those providing care to support older Australians in a way that aligns with their needs, goals and preferences. It also offers some prompts for when plans and support strategies should be reviewed and when referral to other health professionals may be necessary.

The resources provided in this guide do not replace the need for a specialised level of assessment to determine the type and causes of incontinence. Typically, this specialised assessment is performed by a doctor or registered nurse with specialist knowledge and skills in continence management, such as a Nurse Continence Specialist or Nurse Practitioner.

Acknowledgements

This publication was reviewed by the Continence Foundation of Australia and funded by the Australian Government under the National Continence Program. This version is based on the 'Continence Resources for Residential Aged Care' originally developed by Deakin University and funded under the National Continence Management Strategy.

The health professionals who contributed to the review of this publication are gratefully acknowledged, with special thanks to the following working group members: Dr Joan Ostaszkiewicz (project manager), Dr David Lim, Ms Janie Thompson, Mrs Sue Blinman and Dr Lorraine Dickson.

Disclaimer

This guide should be used as an adjunct to sound clinical judgement and institutional guidelines and protocols for the assessment and management of incontinence in aged care settings.

Creative Commons Licence

Contents

Being sensitive to the personal nature of incontinence

Talking about bladder and bowel function is difficult for most people. An important factor to consider when conducting a continence assessment is the person's right to privacy. The way in which information is obtained about a person's continence status, such as the frequency of voiding, frequency of bowel actions, or levels of assistance required to use the toilet should be done sensitively.

Explaining why you want to assess the person's bladder/ bowel function is important, as is explaining the nature of the assessment. Some people may not understand the nature of a continence assessment or your efforts to help them or to monitor their bladder and bowel function. They may consider this activity of checking their continence status as intrusive, so every effort should be made to consider the person's privacy and ask questions in a discreet and sensitive way.

What form to complete and when

Table 1 Steps to Continence Management

01. Complete the Continence Screening Form

An older person seeking your help may or may not have incontinence or other bladder or bowel symptoms. Completing the *Continence Screening Form* will help you decide whether the person requires a continence assessment.

If you answer 'yes' or 'don't know' to any question — go to **STEP 2**.

02. Complete the Three-Day Bladder Chart and Seven-Day Bowel Chart

Completing the *Three-Day Bladder Chart* and *Seven-Day Bowel Chart* will provide important information to help you identify the person's continence care needs. It will also provide the relevant information to complete the Continence Assessment Form and Care. If ongoing bowel management is required, use the Monthly Bowel Chart. Once completed, go to **STEP 3**.

03. Complete the Continence Assessment Form and Care Plan

Completing the *Continence Assessment Form and Care Plan* will ensure you identify the person's continence care needs and develop a continence care plan that is partnership-centred, evidence-based and individualised.

Once completed, go to **STEP 4**.

04. Complete the Continence Care Summary

Completing the *Continence Care Summary* provides you with a workplan that outlines the activities that need to be performed to meet the person's day-to-day continence care needs.

Once completed, implement the Continence Care Plan and go to **STEP 5**.

05. Review the effectiveness of the Continence Care Plan

The person's continence status should be reviewed on a regular basis (i.e. consistent with your organisation's policies) AND if there is a change in the person's continence. Conducting a regular review will tell you whether the person's continence care plan is effective or not.

Repeat **STEPS 2**, **3** & **4**.

Continence Screening Form (see Appendix 1)

Screening for incontinence provides a means to identify symptoms that warrant further attention, assessment and/or referral. By completing the *Continence Screening Form*, you will obtain information to help you decide whether the person requires a continence assessment.

The form has been designed to help you to enquire about relevant bladder symptoms, bowel symptoms, any history of bladder or bowel problems, whether the person uses or wears a continence product, and whether they require any specialised intervention to use their bladder or bowel.

Frequently asked questions about completing the *Continence Screening Form*	
What is the purpose of the *Continence Screening Form*?	Although some people who use an aged care service will have a bladder and/or bowel problem, others will not. The purpose of the *Continence Screening Form* is to help you decide who requires a continence assessment.
When should the *Continence Screening Form* be completed?	The *Continence Screening Form* should be completed when a new person is admitted to the service.
Who should complete the *Continence Screening Form*?	The *Continence Screening Form* is designed to be completed by a health care professional/worker who has the necessary knowledge and skills to complete the form. If the person is unable to answer the questions, consider consulting their representative where appropriate.
What should be done with the information from the *Continence Screening Form*?	If you ticked 'yes' or 'don't know' to any of the questions, please initiate the *Three-Day Bladder Chart* and/or the *Seven-Day Bowel Chart*.

Three-Day Bladder Chart (see Appendix 2)

Information from the Three-Day Bladder Chart helps to:

- Complete Section E of the Continence Assessment Form and Care Plan (Bladder & Bowel Symptoms)
- Determine if the person has a predictable pattern of voiding (passing urine)
- Develop a continence care plan that is responsive to the person's needs
- Review the circumstances associated with the person experiencing urinary incontinence

Frequently asked questions about completing the *Three-Day Bladder Chart*	
When should the *Three-Day Bladder Chart* be commenced?	The best time to commence the *Three-Day Bladder Chart* is after the person is settled and familiar with their surroundings. This timing will vary from person to person, but usually it can be commenced once the person's health status is stable. The *Three-Day Bladder Chart* may be appropriate to use at other times such as when you are reviewing the person's continence status or when you wish to monitor the effectiveness of care.
Who should complete the Chart?	The *Three-Day Bladder Chart* is designed to be completed by a health care professional/worker who has the requisite knowledge and skill. Questions should be directed to the person. If they are unable to answer the questions, consider consulting their representative where appropriate.
Why maintain the Chart for three days?	The *Three-Day Bladder Chart* should be maintained for a minimum period of 3 complete and consecutive 24-hour periods (including day and night). If the care recipient is unavailable for 24 hours (e.g.: illness or outing) when completing the record over consecutive days, **an extra 24 hours can be added at the end of the recording period** and the reason for the absence or unavailability on the missed day is to be noted on the record. Three days is the average time that it takes to identify a person's bladder patterns. Some people may need a longer period of monitoring.
How frequently should person's urinary continence status be checked?	It is preferable to monitor the frequency of the person's bladder elimination and urinary continence status closely during the assessment period. More frequent observations provide more accurate information on which to base a care plan. At the same time the frequency of checks and the manner in which they are conducted should not interfere with the person's usual activities. The *Three-Day Bladder Chart* is divided into: (i) waking to morning tea; (ii) morning tea to lunch; (iii) lunch to afternoon tea; (iv) afternoon tea to dinner; (v) dinner to bed; and (vi) overnight. Please complete the chart each time the person passes urine, regardless of whether they are continent or incontinent.

How is information collected to complete the *Three-Day Bladder Chart*?	Ideally, information to complete the *Three-Day Bladder Chart* should be provided by the person themselves. However, this is not always possible. Identify if the person is continent or not during the designated time periods. Discreetly observe for urine loss when providing personal care (i.e. during toileting or hygiene assistance). If the person is using a pad, check for a wetness indicator (usually located on the outside of pad). Also observe and document how many drinks the person has within the designated time periods; what type and what amount. In assessing a person's continence status, it can be very helpful to know the person's voided volume (i.e. the amount the person passes in millilitres) each time they pass urine over a 24-hour period for three days. If the person is continent, this information can be obtained by placing a measuring device in their toilet. If the person is incontinent and wears a pad, estimate the degree of wetness (i.e. pad only, underwear, outer clothing and bedding).
What information is required?	The *Three-Day Bladder Chart* documents: ▶ The time the person has a drink (include fluid from foods such as soups) ▶ The type and amount of fluid consumed ▶ The time the person passes urine (voids) ▶ The amount/volume of urine the person passes (voids) ▶ Whether the person is incontinent at the time they pass urine ▶ If the person is incontinent, the degree of wetness (i.e. whether only the pad is wet, the underwear, the outer clothing, and/or the bedding) ▶ The number of pad or clothing changes the person requires during each designated timeframe (i.e. between waking to morning tea; morning tea to lunch; lunch to afternoon tea; afternoon tea to dinner; dinner to bed; and overnight) ▶ The circumstances of the incontinence and the effects on the person's life ▶ The total intake, total voided volume, total number of incontinent episodes, and the total number of pad/clothing changes

Using the **Three-Day Bladder Chart** to identify a predictable pattern of urinary continence and incontinence

Some people have a predictable pattern of passing urine, and of urinary continence and incontinence, particularly if they live in a stable environment where there are set times for meals, fluid intake, medication, activities, rest and sleep. Most people pass urine (void) when they first wake up in the morning, and at three to four hourly intervals throughout the day. In addition, most people over the age of 65 years of age pass urine at least once overnight.

How to identify a predictable voiding pattern:

- **STEP 1:** Review the person's *Three-Day Bladder Chart*
- **STEP 2:** Identify from the chart if the person has a predictable voiding pattern
  - Does the person pass urine at consistent (regular) times?
- **STEP 3:** If 'no', consider implementing a Timed Toileting Assistance Program (see below)
  - If 'yes', document these times on a **toileting assistance grid** (such as the one included with the *Continence Assessment Form and Care Plan*)
- **STEP 4:** Offer or provide toileting assistance 20–30 minutes prior to the documented times
- **STEP 5:** Review the effectiveness of the program
- **STEP 6:** Adjust the toileting assistance times accordingly

Individualised Toileting Assistance Programs are suitable for people who have predictable voiding patterns. Implementing an Individualised Toileting Assistance Program involves: (i) identifying the person's usual voiding pattern and (ii) verbally prompting or physically assisting them (or both) to use the toilet prior to the predicted or anticipated voiding time.

If the person **does not have** a predictable pattern of urinary continence and incontinence and requires assistance, prompting or supervision to use the toilet, they may benefit from a Timed Toileting Assistance Program. The GRID on the Continence Assessment Form and Care Plan can be used to indicate the times the person requires assistance.

Timed Toileting Assistance Programs rely on carers offering verbal prompts or physical assistance, or both, to a person to use the toilet at predetermined fixed voiding intervals, such as every two to four hours, regardless of whether the person has an urge to void or not.

Seven-Day Bowel Chart (see Appendix 3)

Information from the *Seven-Day Bowel Chart* can help you to:

- Determine the frequency of bowel elimination and faecal incontinence
- Complete section F of the *Continence Assessment Form and Care Plan* (Bowel Management)
- Determine if the person has a predictable pattern of using their bowels
- Determine if the person is constipated
- Develop a continence care plan that is responsive to the person's needs

Frequently asked questions about completing the *Seven-Day Bowel Chart*	
When should the *Seven-Day Bowel Chart* be commenced?	The best time to commence the *Seven-Day Bowel Chart* is when the person is settled and familiar with their surroundings. This timing will vary from person to person, but usually it can be commenced once the person's health status is stabilised. The *Seven-Day Bowel Chart* may also be used when you are reviewing the person's bowel management program and when you wish to monitor the effectiveness of care.
Why maintain the Chart for seven days?	The *Seven-Day Bowel Chart* should be maintained for a minimum period of 7 complete and consecutive 24-hour periods (including day and night). If the care recipient is unavailable for 24 hours (e.g.: illness or outing) when completing the record over consecutive days, **an extra 24 hours can be added at the end of the recording period** and the reason for the absence or unavailability on the missed day should be noted on the record. Seven days is the average time that it takes to identify a person's bowel patterns. Some people may need a longer period of monitoring.
How frequently should a person's bowel continence status be checked?	It is preferable to monitor the frequency of the person's bowel elimination and bowel continence status closely during the assessment period. More frequent observations provide more accurate information on which to base a care plan. The frequency of checks and the way they are conducted should not interfere with the person's usual activities.
How is information collected to complete the *Seven-Day Bowel Chart*?	Ideally, information to complete the *Seven-Day Bowel Chart* should be provided by the person themselves. However, due to dementia and other health-related conditions, this is not always possible. Identify if the person is continent or not during the designated time periods. Discreetly observe for faecal loss when providing personal care (i.e. during toileting or hygiene assistance). If the person is using a pad, check this for soiling.

What information is required?	The *Seven-Day Bowel Chart* allows you to document the following information: ▶ The time of day/night that the person has a bowel motion ▶ The type of bowel movement (i.e. the consistency of the bowel motion — with reference to the Bristol Stool Chart — Appendix 5) ▶ Whether the person is incontinent of faeces ▶ The number of pad/ clothing changes when/ if the person is incontinent of faeces ▶ Whether the person is given an aperient/ suppository/ antidiarrhoeal/ enema etc. ▶ The circumstances associated with the person experiencing faecal incontinence and the effects on the person's life

Using the **Seven-Day Bowel Chart** to identify a predictable pattern of faecal continence and incontinence

Diet, exercise, time of day, and changes to a person's normal surroundings affect the timing of bowel actions. Some, but not all people have a predictable pattern of using their bowels, and/or of faecal continence and incontinence. Review the information collected over the seven-day period to decide whether or not the person has a predictable pattern of faecal continence and incontinence. If so, and if they require assistance, prompting or supervision to use the toilet, they may benefit from a Bowel Management Program that is based on this pattern. If not, ensure they have the opportunity to use their bowel on a regular and daily basis.

A **Bowel Management Program** is a program to help a person achieve bowel elimination that meets their needs, goals and preferences.

The program should be individualised and based on an assessment of the person's specific bowel problems or risk of bowel problems. It may include strategies or interventions to prevent or treat bowel problems.

Monthly Bowel Chart (see Appendix 4)

By completing the Monthly Bowel Chart, you will obtain the same information as provided by the Seven-Day Bowel Chart.

The advantages of using the Monthly Bowel Chart is that it provides more comprehensive and accurate information about the person's bowel function because it represents a longer period of data collection.

Information from the Monthly Bowel Chart can help you to:

- Determine the frequency of bowel elimination and faecal incontinence
- Complete section B of the Continence Assessment Form and Care Plan (Bladder & Bowel Symptoms)
- Determine if the person has a predictable pattern of using their bowels
- Determine if the person is constipated
- Develop a continence care plan that is responsive to the person's needs

Frequently asked questions about completing the *Monthly Bowel Chart*	
When should the *Monthly Bowel Chart* be used?	When no predictable pattern of bowel usage has been determined using the *Seven-Day Bowel Chart* you are advised to complete a *Monthly Bowel Chart*. Some people require ongoing monitoring of their bowel elimination, particularly those who may be unable to communicate any changes to bowel function. The *Monthly Bowel Chart* has been designed to help you monitor and document the person's bowel function on an ongoing basis.
Why maintain the Chart for a month?	Collecting data for a month provides more comprehensive and accurate information to complete a care plan that is responsive to a person's needs.
What information is required?	The *Monthly Bowel Chart* allows you to document the following information: ▶ The time of day/night that the person has a bowel motion ▶ The type of bowel movement (i.e. the consistency of the bowel motion — with reference to the Bristol Stool Chart — refer to Appendix 5) ▶ Whether the person is incontinent of faeces ▶ Whether the person is given an aperient / suppository / antidiarrhoeal / enema, etc.

Continence Assessment Form and Care Plan (see Appendix 6)

The Continence Assessment Form and Care Plan is designed to help assess the person's continence care needs and develop an individualised continence care plan for the person.

It consists of a number of assessment cues (or questions). There is also a list of care options that are linked to these cues that guide continence management.

It is divided into the following sections:

A. Continence care goals and preferences

B. Usual management

C. Functional considerations

D. Skin health

E. Bladder management

F. Bowel management

G. Urinalysis (Dipstick)

H. Medical considerations

Frequently asked questions about completing the *Continence Assessment Form and Care Plan*	
Why should the *Continence Assessment Form and Care Plan* be completed?	Conducting a continence assessment will help you to identify the person's continence care needs. Some people have bladder and bowel symptoms that require a more specialised assessment. The form contains triggers to help you to identify which person needs more specialised assessment.
When should the *Continence Assessment Form and Care Plan* be commenced?	The *Continence Assessment Form and Care Plan* should be completed once the *Three-Day Bladder Chart* and *Seven-Day Bowel Chart* are complete. The best time to commence the *Continence Assessment Form and Care Plan* is when the person is settled and familiar with their surroundings. This timing varies from person to person.

Section A: Continence Care Goals and Preferences

Goals of care

- Ensure that a person's personal goals and preferences are respected to allow them to live the life they choose
- Ensure the person and their representative where appropriate are informed about strategies to promote healthy bladder and bowel function
- Ensure the person's and/or their representative's expectations and care goals align
- If the person is bothered by their symptoms, discuss this with the RN or Doctor

The first and most important part of any continence assessment is to identify the person's continence care goals and preferences, including their understanding about the nature of their symptoms. If the person has a bladder or bowel problem, provide them with information about the types of support available, how to access it and further assessment and intervention.

Q. Bladder problem	Rationale & care options
1. Is the person currently experiencing a bladder problem? ☐ Yes ☐ No If 'yes', how does it affect them?	The continence assessment involves establishing the nature of the problem from the perspective of the person concerned and the impact on their lives. It is common for people with severe incontinence to restrict their activities and avoid social occasions. Try to evaluate the impact of symptoms on the person's personal and social life.
2. Does the person have a history of a bladder problem? ☐ Yes ☐ No If 'yes', what was or is the problem?	Urinary incontinence and other bladder symptoms are common in the general community. Bladder problems may be longstanding or recent. If the person has a bladder problem, try to elicit information from them about the nature of the problem and how long they have had it.
3. If 'bladder problems', what kind of support would they prefer? ☐ Independent ☐ To be assisted to go to the toilet at ..... (specify preferred toileting times) ☐ To wear an incontinence aid during the day ☐ To wear an incontinence product during the night ☐ To be seen by a specialist for further investigation ☐ Other.....	The continence assessment involves establishing the person's preferences for care. This question has been designed to help you establish their expectations and preferences in relation to any bladder problems they may be experiencing. It should be completed only if they have a bladder problem. If they are unable to answer the question, consider asking their representative where appropriate.

Q. Bladder problem	Rationale & care options
4. Is the person currently experiencing a bowel problem? ☐ Yes ☐ No If 'yes', what is the nature of the problem?	The continence assessment involves establishing the nature of the problem from the perspective of the person concerned and the impact on their life. It is common for people with severe incontinence to restrict their activities and avoid social occasions. Try to evaluate the impact of symptoms on the person's personal and social life.
5. Does the person have a history of a bowel problem? ☐ Yes ☐ No If 'yes', what was or is the problem?	Faecal incontinence and other bowel symptoms are common in the general community. It is possible that the person has a longstanding bowel problem. Alternatively, it may be a recent occurrence. If the person has a bowel problem, try to elicit information from them about the nature of the problem and how long they have had it.
6. If 'bowel problems', what kind of support would they prefer? ☐ Independent ☐ To be assisted to go to the toilet at ..... (specify preferred toileting times) ☐ To wear an incontinence product during the day ☐ To wear an incontinence product during the night ☐ To have a regular aperient ☐ To be seen by a specialist for further investigation ☐ Other.....	The continence assessment involves establishing the person's preferences for care. This question has been designed to help you establish their expectations and preferences in relation to any bowel problems they may be experiencing. It should be completed only if they have a bowel problem. If they are unable to answer the question, consider asking their representative where appropriate.

Section B: Usual Management

Goals of care

- Ensure the person and their representative are aware of the types of products that can assist with toileting
- Ensure the person and their representative are aware of the types of products that can be used to contain incontinence
- Ensure the person and their representative are aware of the types of products that can help manage urinary retention
- Ensure that any incontinence product being used by the person keeps them clean, dry and comfortable

The ability to contain incontinence is crucial to one's sense of wellbeing. If the use of incontinence products is effective, the person will feel dry, clean and comfortable, and their incontinence will be contained and concealed.

As some older people who require aged care services may have a pre-existing problem of incontinence, they may have already established a management strategy, which may or may not be effective.

It is important to consider their past management when assisting them to choose the most appropriate form of management for incontinence.

Further independent evidence-based information about the range of different incontinence products is available from the following:

National Continence Helpline
1800 33 00 66
continence.org.au
continenceproductadvisor.org

Q. Bladder problem	Rationale & care options
7. Does the person use or wear a product to help maintain their social incontinence? ☐ Yes ☐ No If 'yes', what type of product is it?	There are many different types of incontinence products available to help people maintain their continence. Some products assist with toileting, some contain urinary or faecal incontinence and some help to manage urinary retention.

Q. Bladder problem	Rationale & care options
8. Does the person use an aid to assist with their toileting? ☐ Yes ☐ No If 'yes', what type of product is it?	Products to assist with toileting include urinals, commodes and bedpans. When choosing a product to help contain incontinence, consider the type of incontinence the person may have, its severity, the person's mobility and functional dexterity, their skin health and protection and their personal goals and preferences. Confirm cost of product, the person's eligibility to access financial support to purchase the product, product availability, its absorbency, its shape and comfort, how to dispose of the product and whether or not the person can manage the care associated with the product (i.e. apply, remove and dispose of it). Products include: ▶ Disposable or washable absorbent products (commonly known as incontinence pads or pants) ▶ Inserts (liners), all-in-ones, pull-ups, male pouches, underpads (for chair/bed) ▶ External urine collection devices for men: Urinary sheaths (condom catheters), male body worn urinals and dribble containers ▶ Mechanical devices for men with urinary incontinence (i.e. penile clamps/ compression devices)
9. Does the person have a catheter? ☐ Yes ☐ No If 'yes', what type of product is it?	If the person has a catheter it is important that they have a Catheter Plan that staff **must** follow. *If the person has a catheter omit **SECTION E** of the *Continence Assessment Form and Care Plan*.

Section C: Functional Considerations

Goals of care

- Aim for the person to participate as much as possible in toileting activities to remain as mobile and independent as possible where consistent with the person's goals and preferences.

A loss of independence and mobility is a major reason for incontinence in older people.

There are many factors that may make it difficult for an older person to reach and use the toilet independently, including neurological conditions that affect physical and/or cognitive function. Exercise programs that maintain or restore a person's strength can improve their independence to use the toilet, as well as improve overall quality of life.

Q. Assessment cue	Rationale & care options
10. Does the person indicate their need for assistance with toileting/continence care? ☐ Yes ☐ Sometimes ☐ No	Some medical conditions impair a person's ability to identify the urge to pass urine or use their bowels. This could be due to a lack of sensation or because they are unable to interpret the sensation. Another consideration is that the person may have lost their ability to verbally communicate the need for assistance, because of speech or cognitive impairment. Observe the person for individual behaviours such as agitation and pulling at clothing that indicate they need to use the toilet.
11. Can the person identify the location of the toilet? ☐ Yes ☐ Sometimes ☐ No	Some people have medical conditions that make it difficult for them to identify the location of and/or to use the toilet. Remind the resident to go to the toilet regularly and provide direction if required. Other strategies include placing the person close to the toilet, leaving the toilet light on at night and ensuring the toilet is easy to identify.

Q. Assessment cue	Rationale & care options
12. Can the person walk to, and use the toilet? ☐ Yes, independently ☐ Sometimes ☐ No, requires supervision ☐ No, requires lifting equipment	Walking is critical for the maintenance of continence. Mobility programs have been shown to improve older peoples' continence status. If the person is unable to walk to the toilet or if this involves unnecessary risk or pain, consider the use of other devices (i.e. bedpans, urinals, commodes or absorbent pads).
13. Can the person undress and redress for toileting? ☐ Yes ☐ Sometimes ☐ No	There are a number of factors and conditions that may make it difficult for a person to complete all aspects of the toileting procedure. If dressing/undressing is a challenge, consider encouraging the person to wear clothing that is easy for them to manage.
14. Can the person wipe themselves? ☐ Yes ☐ Sometimes ☐ No	Some people need help to wipe themselves after passing urine or using their bowels. Provide assistance as required. Consider offering pre-moistened wipes.
15. Does the person co-operate with attempts to assist them to the toilet or with changing? ☐ Yes ☐ Sometimes ☐ No	It is not uncommon for people who are cognitively impaired to resist carers' efforts to provide them with toileting assistance, or other aspects of continence care. Resistance should signify that the person does not understand or agree with the care. You should: ▶ Anticipate and avoid any action that could cause or exacerbate distress ▶ Employ distraction techniques and humour to help the person better accept care ▶ Defer the activity until the person finds it more acceptable
16. Does the person experience pain that restricts their toileting ability? ☐ Yes ☐ Sometimes ☐ No	Pain can reduce a person's mobility and exhaust their physical and emotional reserve. It may also deter them from going to the toilet. This is also true for some people with dementia. If the person is unable to walk to the toilet or if this involves unnecessary risk or pain, consider the use of other continence products (i.e. bedpans, urinals, commodes or absorbent pads). It is also important to ensure the person's pain is investigated and treated.

Section D: Skin Health

Goals of care

- Aim for the person's skin to remain intact and free from rashes, excoriation and pressure injuries.

Skin provides a barrier to elements such as heat, moisture and bacteria. Constant exposure to urine and faeces may put the skin at risk, causing incontinence-associated dermatitis (IAD) and subsequent pressure injuries.

Q. Assessment cue	Rationale & care options
17. Does the person'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, ulcerated, have a rash or have lumps and blotches ☐ Other (specify).....	If you are concerned about the appearance of the person's skin, it is important to ask the RN/Doctor about the care/further assessment required.

Strategies to minimise the risk of incontinence-associated dermatitis (IAD) and pressure injuries

- Skin that is soiled with urine and / or faeces should be cleaned immediately if possible or promptly after episodes of incontinence
  - Use a non-irritating, pH neutral product (i.e. avoid using scented soap) and avoid mechanical damage to the skin
- Establish an individualised schedule for cleansing the person's perineum according to their needs or preferences, or at routine intervals, such as daily or at bath time
- Change wet pads, linen and clothing soon after incontinent episodes
  - Prolonged occlusion of wet skin (as within an incontinence product) reduces the skin's ability to function as a barrier against infection and incontinence-associated dermatitis (IAD)
  - Less frequent pad changes may be associated with pressure injuries
  - It is not always easy to know when an absorbent pad/pant needs to be changed, particularly if the person does not perceive the need to be monitored and is unaware of their continence status. If the person is wearing a disposable absorbent pad/pant, it may have a wetness indicator on it that acts as a guide to let you know when to change it. Another strategy is to keep track of when the pad/pant was applied and to institute a program of regular checks
- Apply skin creams (i.e. moisturisers or barrier skin creams) to areas that come in contact with leaked urine and / or faeces (i.e. the buttocks and perianal area, groin, and inner thighs
  - Choose a cream that is suitable for use with incontinence products
  - Avoid thick layering of barrier creams as these can rub off on absorbent pads/ pants, rendering them ineffective at absorbing the urine
- If an incontinence product is used, ensure it is of good quality and that it contains the degree of wetness. If the product leaks, it is likely the skin will be unnecessarily exposed to moisture

Section E: Bladder Management

Goals of care

- Aim for the person to be continent and to void 4–8 times a day and no more than 2 times at night
- Assess the person's risk for falling if they need to go to the toilet at night
- Aim for the person to be adequately hydrated and well nourished

Most people pass urine 4–8 times a day and, if under 65 years of age, one to two times at night. If the person passes urine too frequently or infrequently, they may require a medical assessment, as this may be a sign of an underlying abnormality. If they need to pass urine at night, it is important to assess their risk for falling. Strategies for daytime continence care may need to be different than for night-time care.

Q. Assessment cue	Rationale & care options
18. What time does the person normally go to bed in the evening? **What time does the person normally get up in the morning?**	There is a wide range of sleeping patterns among older adults. Some older adults will spend six hours sleeping while others might spend twelve hours in bed. For example, if a person spends up to 12 hours in bed at night, then having to get up three times to pass urine during this time is within the normal range.
19. During the day, how many times does the person pass urine/go to the toilet on average? (from waking in the morning to bedtime at night) ☐ Less than 3 times ☐ 4–8 times ☐ More than 8 times	Older people pass urine more frequently than younger people (up to 8 times a day). There are many factors that increase urinary frequency in older people, including medications such as diuretics. If a person passes urine less than 3 times a day or more than 8 times a day, this should be reported to the RN. It is important for the RN to assess if there are any medical conditions or reversible factors that are causing the problem and, if so, how bothersome the person's frequency of passing urine is to them.

Q. Assessment cue	Rationale & care options
20. During the night, how many times does the person pass urine/go to the toilet on average? (from bedtime at night to waking in the morning) ☐ None ☐ Twice ☐ 3 or more times	Waking at night from sleep one or more times to pass urine is called 'nocturia'. Older people are more likely to experience nocturia due to age-related conditions. Nocturia affects nearly 50% of men aged 70–79 years and is two times more common in men than in women. If the person has nocturia two or more times, it is important to ask the RN/Doctor about the care/further assessment required to ensure that any underlying medical conditions are identified and treated. Another factor to consider is the person's risk of falling at night if they attempt to respond quickly to the urge to pass urine. Refer to the falls care plan for strategies to minimise the person's risk of falling at night. Consider these general care options and implement continence care that is consistent with the person's preferences: ▶ Offer a bedside commode as an alternative to the toilet ▶ Ensure the call bell is within reach ▶ Turn the nightlight on ▶ Turn sensor/s on ▶ Offer toileting assistance if person is awake
21. Does the person have urinary leakage during the day? ☐ Yes If yes, how often?..... ☐ Once every few days ☐ Once a day ☐ Several times a day ☐ Most or every time ☐ No	There are many reasons for a person to experience daytime urinary incontinence. Ask the RN/Doctor to assess if there are any medical conditions or reversible factors that are causing the problem. Conducting a continence assessment will help identify possible causes and develop a care plan. Some people will respond to a Toileting Assistance Program. If the person accepts wearing a continence product, they may need help to change it on a regular basis, particularly if they are cognitively impaired or have problems with their physical dexterity. If the person is cognitively impaired, it is important to check their continence status regularly. The Continence Product Check GRID has been designed for you to indicate the times to check the person's continence status.

Q. Assessment cue	Rationale & care options
22. Does the person have urinary leakage during the night? ☐ Yes If yes, how often?..... ☐ Once every few nights ☐ Once a night ☐ Several times a night ☐ Most or every time ☐ No	If the person leaks urine several times or more at night, ask the RN/Doctor to assess if there are any medical conditions or reversible factors that are causing the problem. Management options may include: ▶ Prompting and/or assistance to get to the toilet overnight ▶ A commode beside the person's bed or a urinal, bedpan or call bell, or leaving a dim light on in the toilet
23. Does the need to pass urine or incontinence at night make it difficult for the person to go back to sleep? ☐ Yes ☐ Sometimes ☐ No ☐ N/A	For many people nocturia is not a problem, however for others it is disruptive and they find it difficult to get back to sleep. Disrupted sleep can severely impact on a person's overall quality of life and wellbeing. If the person has difficulty getting back to sleep after waking to go to the toilet, it is important to ask the RN/Doctor about the care/further assessment required to ensure that any underlying medical conditions are identified and treated.
24. Does the person have a predictable pattern of passing urine (including urine leakage)? ☐ Yes ☐ No	If 'yes', the person has a predictable pattern of passing urine, they may respond to an Individualised Toileting Assistance Program where you prompt and/or assist them to the toilet at times that are based on their usual pattern. If 'no', they may respond to a Timed Toileting Assistance Program. This involves prompting/assisting the person to the toilet at fixed regular intervals. Alternatively, if the person is not suitable for a Toileting Assistance Program at all, you may need to put in place an alternative strategy.

Section F: Bowel Management

Goals of care

- Aim for the person to have a regular continent, soft formed stool (i.e. Bristol Stool Chart type 3 or 4 that is easy to pass at least 3 per week)
- Monitor the person's bowel elimination frequency and consistency
- Encourage the person to respond to the urge to use bowels
- Promote proper position for bowel elimination (leaning forward with feet flat on floor)
- Aim for the person to be hydrated and well nourished

There is considerable variability in how many times people use their bowels (i.e. from 3 times a day to 3 times a week). The majority of people need to use their bowels at a consistent time each day. The most common time is after a hot drink and following a meal in the morning. If the urge to use one's bowels is ignored, it can lead to constipation.

Some people need encouragement or prompting to respond to the urge to use their bowel and assistance with toileting. They may also require you to monitor their bowel elimination frequency and consistency, particularly if they are cognitively impaired. Although privacy to defecate is important, monitoring is required for people with advanced dementia as they are at high risk for constipation.

'Untreated bowel problems can be fatal to an older person and require immediate attention. It is important that each person's bowel chart is reviewed at least once every 48 hours to monitor for [a] potential problem.'

(University of Western Sydney, 2009. p. 6).

Specialised interventions

Some people, particularly those with a neurological disorder, may require a medically prescribed program to empty their bowels and maintain regular bowel elimination. If expert advice is required, the RN may need to consult with the person's doctor or other specialised treating teams.

Q. Assessment cue	Rationale & care options
25. How often does the person normally use their bowels? ☐ More than 3 times a day ☐ Between 3 times a day & 3 times a week ☐ Less than 3 times a week	Another factor to consider is the person's risk of falling at night if they attempt to respond quickly to the urge to pass urine. Refer to the falls care plan for strategies to minimise the person's risk of falling at night. Consider these general care options and implement continence care that is consistent with the person's preferences: ▶ Offer a bedside commode as an alternative to the toilet ▶ Ensure the call bell is within reach ▶ Turn the nightlight on ▶ Turn sensor/s on ▶ Offer toileting assistance if person is awake ▶ As people age, the bowel and the gut are slower. For older people, this change in bowel function does not usually cause problems. However, when combined with reduced mobility, reduced food and fluid intake, constipation may develop. If 'more than 3 times a day' or 'less than 3 times a week', ask the RN/Doctor about the need for bowel medication such as an aperient, suppository, antidiarrhoeal, or enema, or for increased or decreased fluid intake and/or fibre supplement.
26. Does the person have a predictable pattern of using their bowels (including faecal incontinence)? ☐ Yes ☐ No	Some, but not all people have a predictable pattern of using their bowels, and/or of faecal continence and incontinence. Review the information collected over the seven-day period to decide whether or not the person has a predictable pattern of using their bowels. If 'yes' and if the person requires prompting or supervision to use the toilet, implement an Individualised Toileting Assistance Program that is based on this pattern. If the person does not have a predictable pattern of using their bowels, it is still important to ensure they have the opportunity to use their bowels on a regular and daily basis.

> **"Untreated bowel problems can be fatal to an older person..."**
>
> University of Western Sydney, 2009. p. 6

Q. Assessment cue	Rationale & care options
27. In the past two weeks, has the person had any episodes of faecal incontinence? ☐ Yes ☐ No	There are many factors that can combine to cause faecal incontinence or loose bowel motions. If the person has faecal incontinence or regular loose bowel motions, they should be reviewed by an RN/Doctor. Care interventions include: ▶ Monitoring and reporting episodes of faecal incontinence ▶ Assisting the person to wear/change a continence pad/product ▶ Changing the person's soiled incontinence pads/products, linen and clothing soon after incontinent episode ▶ Protecting the person's skin from the damaging effects of faecal matter — refer to skin care options
28. Does the person have any of the following symptoms when they use their bowels? ☐ Pain/discomfort ☐ Straining ☐ Bleeding ☐ Hard/dry bowel motions ☐ Liquid bowel motions — Bristol type 6 or 7	It is important to ask the RN/Doctor about the care/further assessment required as these symptoms are often associated with constipation, faecal impaction or some other anal/rectal pathology. The sudden onset of very loose or watery motions may indicate acute diarrhoea. This could indicate the onset of viral or bacterial gastroenteritis. Viral gastroenteritis is highly infectious and requires immediate action.

Q. Assessment cue	Rationale & care options
29. Is there a problem with the person's fluid intake? ☐ Yes ☐ No	A lack of fluid intake increases the risk of incontinence and constipation. Many older people do not drink enough and are at risk of developing dehydration which can adversely affect their cognitive ability. Drinking too much fluid is also cautioned, particularly if the drink contains alcohol, coffee or too much sugar which may irritate the bladder. If there is a problem with the person's fluid intake, ask the RN/Doctor about the care/further assessment required and their recommended fluid intake. It is also important to monitor and document what some people drink and provide them with the necessary levels of assistance to ensure they remain well hydrated. People with moderate cognitive impairment may need regular prompting or physical assistance to drink.
30. Is there a problem with the person's food intake? ☐ Yes ☐ No	A diet that is not individualised for the person can cause considerable problems, including weight loss, low levels of energy and ill health. It can also lead to bowel problems that present as either constipation or faecal incontinence or loose bowel actions. If there is a problem with the person's food intake, ask the RN/Doctor about the care/further assessment required and their recommended fluid intake. Depending on the underlying nature of the problem, the person might be helped by a dietician or speech therapist. It may be important to monitor and document what the person eats and provide them with the necessary levels of assistance to ensure they remain well nourished. People with moderate cognitive impairment may need regular prompting or physical assistance to eat.

Section G: Urinalysis (Dipstick)

Best practice recommendations for the assessment and management of incontinence consider urinalysis to be a fundamental aspect of a continence assessment. However, a dipstick urinalysis is a screening test only and should not be relied upon to make a diagnosis. A positive or negative dipstick indicates the need for further investigation. If the person has any abnormalities on the dipstick urinalysis, the RN or Doctor must be informed and asked about the care or further assessment required.

Complete **SECTION G** on the *Continence Assessment Form and Care Plan* with the urinalysis results.

See page 42 for the detailed list of **Abnormal findings on urinalysis**.

Section H: Medical Considerations

It is important to distinguish between people who have incontinence that may be caused by a potentially reversible cause/condition and those whose incontinence is chronic and not responsive to treatment. Identifying potentially reversible conditions which may be causing or exacerbating incontinence can be challenging in a person who also has dementia or health conditions that make it difficult for them to communicate their needs. Confusion associated with delirium for example may be difficult to distinguish from confusion associated with dementia. Similarly, incontinence, urinary frequency or increased confusion may be the only symptoms evident in residents with bladder infections.

For these reasons, Section H is to be completed by an RN, Continence Nurse or Doctor and with reference to the resident's medical history.

Conducting a continence assessment also involves deciding with the resident and/or family members about the appropriateness of different treatment options (including referral to a specialist). International guidelines for continence care advocate for frail older adults to have equal access to assessment and treatment options as other members of the community. Refer to Table 2 for further information about medical conditions that may cause or contribute to a person's bladder/ bowel symptoms.

Q. Assessment cue	Rationale & care options
31. Has the person had a medical review to identify potentially treatable causes of bladder/ bowel symptoms ☐ Yes ☐ No Are any of the following factors possibly contributing to the person's bladder/bowel symptoms?	Needs to be confirmed they have identified potentially treatable causes of bladder / bowel symptoms. Please refer to Table 2: Medical conditions that may cause or contribute to bladder / bowel symptoms.

Table 2 Medical conditions that may cause or contribute to bladder/bowel symptoms

Category	Condition	Explanation of symptom/condition
Neurological condition	Dementia	Dementia is a syndrome due to disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. Dementia causes acute confusion which may result in the person being unable to perform toileting tasks and/or communicate need for assistance.
	Delirium	Delirium is 'an etiologically nonspecific organic cerebral syndrome characterised by concurrent disturbances of consciousness and attention, perception, thinking, memory, psychomotor behaviour, emotion and the sleep-wake schedule. The duration is variable and the degree of severity ranges from mild to very severe' (ICD-10 Version: 2016). It causes acute confusion which may result in the person being unable to perform toileting tasks and/or communicate the need for assistance.
	Depression	Depression is a mood (affective) disorder with or without associated anxiety, which may be mild, moderate or severe, accompanied by a reduction in energy, a decrease in activity and a lowered mood (ICD-10 Version:2016). It is common in older adulthood and particularly among individuals with multiple health problems. Depression can lessen a person's motivation to engage in self-care activities, including continence care.
	Stroke	Depending on the type of stroke, symptoms may include reduced mobility, communication or cognition issues. It may also have direct effects on bladder and bowel function through complex neurological pathways.
	Spinal cord injury	Depending on the type of spinal injury it may have direct effects on bladder and bowel function through complex neurological pathways.
	Parkinson's disease	Depending on the severity Parkinson's disease may lead to reduced mobility, communication or cognition. The bladder and bowel functions may also be directly affected due to autonomic nerve dysfunction.
	Multiple Sclerosis (MS)	Depending on site of lesions MS may affect the bladder and bowel function in different ways.
	Normal pressure hydrocephalus	Normal pressure hydrocephalus can cause urinary incontinence as part of a triad of symptoms with dementia and gait disturbance.
Gynaecological condition	Atrophic vaginitis	Atrophic vaginitis is caused by a lack of oestrogen to the walls of the vagina and is common in older women. It results in thinning of the vaginal wall and symptoms of stress incontinence. It also causes vaginal irritation. Local oestrogen therapy may be indicated.
	Pelvic organ prolapse	Pelvic organ prolapse may be associated with urge, stress or overflow incontinence. The prolapse may involve the bladder, vagina, bowel or uterus.

Category	Condition	Explanation of symptom/condition
Comorbid medical conditions	Diabetes mellitus	Diabetes mellitus can cause urinary frequency, urgency and urge incontinence because of the presence of glucose in urine. This in turn can be irritating to the bladder wall. Longstanding diabetes may also cause damage to the nerve supply to the bladder and/ or bowel. Stabilising the person's diabetes may improve bladder and bowel function.
	Degenerative joint disease	Degenerative joint disease may reduce function and mobility thus leading to physical issues with toileting. It may affect dexterity which affects use of urinal. Painkillers may lead to constipation.
	Congestive heart failure	Congestive heart failure may require medications which increase urinary volume, urgency and frequency. It may be associated with lower limb swelling which often causes increased urination at night.
	Chronic pulmonary disease	Chronic pulmonary disease may cause a chronic cough which may cause stress incontinence.
	Asthma	Asthma may cause a chronic cough which may cause stress incontinence.
Urological disorders	Enlarged prostate	As men age, their prostate increases in size and in some cases, this can result in voiding problems. Symptoms include urinary frequency, difficulty passing urine (hesitancy), nocturia and a sense of incomplete emptying. A referral to a urologist may be indicated.
Bladder disorders	Symptomatic urinary tract infection	Symptomatic urinary tract infections cause bladder irritation which in turn can cause symptoms of urgency and urge incontinence.
	Voiding dysfunction	Any condition where there is poor coordination between the bladder and the urethra.
	Urinary incontinence	Term used to describe poor bladder control.
Bowel disorders	Constipation	Faecal impaction is often accompanied by reduced perianal and rectal sensation, resulting in a reduced sensory urge to defecate. The typical presenting symptoms include abdominal pain and distention, nausea, vomiting and anorexia, and in older adults, diarrhoea and faecal incontinence are common symptoms. Faecal impaction can affect the bladder by causing symptoms of urgency and urge incontinence, or pressure caused by faecal impact may affect bladder emptying.
	Faecal impaction	
	Irritable bowel syndrome	Irritable bowel syndrome can cause symptoms of faecal urgency, faecal incontinence or, alternatively, may result in constipation and incomplete bowel emptying. It often responds to dietary measures.
	Faecal incontinence	Describes the passing of faeces or wstools at the wrong time or in the wrong place. Includes passing wind when you don't mean to and finding faecal stains on your underwear.
Functional impairment	Impaired mobility	The inability of a person to use one or more of their extremities, or a lack of strength to walk, grasp, or lift objects. The use of a wheelchair, crutches or walker may be utilised to aid mobility.
	Physical environmental barriers	Any physical object or arrangement of objects that prevents a person from fully participating in social, occupational, recreational and/or personal care activities.

Treatment options

Conducting an evidence-based and partnership-centred continence assessment involves deciding with the person and/or representatives about the appropriateness of different treatment options (including referral to a specialist). International guidelines for continence care advocate for all people to have equal access to assessment and treatment. The following is a list of different options for the treatment of incontinence.

Q.32 Is there any potential to treat or improve the person's bladder/bowel symptoms with the following interventions?

Intervention	Rationale
Medication	There are many different medicines that can be used to treat incontinence. The choice of drug depends on the underlying cause of the problem and the type of incontinence. Doctors and Nurse Practitioners are well-placed to determine whether a person would benefit from medication for incontinence. All providers of care play an important role in monitoring the person's response to medication and/or the potential for side effects during treatment.
Bowel Management Program	A bowel management program is characterised by active interventions to help a person achieve bowel elimination that is consistent with their needs and preferences. The program should be individualised and based on an assessment of the person's specific bowel problems or risk of bowel problems. It may include strategies or interventions to prevent or treat bowel problems.
Bladder Training Program	Bladder training aims to increase a person's bladder capacity. This is done by progressively increasing the interval between the urge to void and passing urine. Bladder training is suitable for people who are cognitively alert, motivated, and able to follow a structured program.
Toileting Assistance Program	Toileting assistance programs target incontinence that may occur because of the inability to reach and use the toilet or bathroom because of functional or cognitive impairment. Toileting assistance programs represent one of many conservative interventions that aim to avoid or minimise episodes of incontinence so that carers can use alternative strategies to manage a care-dependent individual's urinary voiding activity. Unlike pelvic floor muscle training and bladder training, toileting assistance programs do not aim to change bladder function. Toileting assistance programs involve verbally prompting or physically assisting care-dependent individuals to go to the toilet at predetermined fixed voiding intervals or at times that are based on the individual's voiding pattern
Pelvic Floor Muscle Exercises	Pelvic floor muscle exercises are designed to strengthen the pelvic floor muscles which support the bladder, bladder neck and associated pelvic structures. The person is taught to actively tighten and lift the muscles at intervals. Weakness of the pelvic floor muscles may result in incontinence. It is important for women to perform pelvic floor muscle exercises throughout their lives as a preventative measure. A specific pelvic floor muscle training program is suitable for individuals who are cognitively alert, motivated and able to follow a structured program.
Toileting aids	Toileting aids assist a person with functional impairment and may make toileting easier and safer. They can help to maintain dignity and independence for older people and those with a disability.
Referral	There are many different health practitioners who specialise in the treatment of incontinence and treatment options vary depending on the underlying cause of the person's incontinence. It is important to liaise with the person and their Doctor to determine if a referral to a specialist is indicated.

Continence Care Summary (see Appendix 7)

The *Continence Care Summary* allows you to summarise and document the information obtained by completing the *Continence Assessment Form and Care Plan*. You might like to use it as a daily worksheet to help familiarise yourself with the person's day-to-day continence care needs. Keep in mind that if the person's continence status changes, both the *Continence Assessment Form and Care Plan* and the *Continence Care Summary* should be updated.

Frequently asked questions about completing the *Continence Care Summary*	
What is the purpose of the Continence Care Summary?	The *Continence Care Summary* was designed as a daily worksheet or summary of the continence care plan to guide day-to-day continence care.
When should the Continence Care Summary be completed?	The form should be completed at the end of the continence assessment i.e. when the *Continence Assessment Form and Care Plan* are completed.
What information is required?	The *Continence Care Summary* allows you to document the following information: **Q1.** The type of incontinence (i.e. urinary or faecal or both) and whether the person experiences these symptoms during the day or night, or both day and night **Q2.** Whether the person is on a Toileting Assistance Program and, if so, the type of program **Q3.** The level of support the person requires for toileting **Q4.** Any behaviours the person may demonstrate that indicate they need assistance **Q5.** The times during the day the person requires toileting assistance **Q6.** The times during the day and night the person needs their continence product checked **Q7.** The person's daytime continence care needs, goals and preferences **Q8.** The person's nighttime continence care needs, goals and preferences **Q9.** The person's individual requirements for bowel elimination **Q10.** The person's individual requirements for skin care

Reviewing a Person's Continence Care Needs

It is important to regularly review the person's continence status. Conducting a regular review will tell you whether the person's continence care plan is effective or not.

It will also tell you whether the person's continence status has deteriorated. By identifying changes in a person's continence status early, you will be able to address potentially reversible conditions in a timely manner and improve the person's quality of life by providing symptomatic treatment.

Repeat Steps 2, 3 & 4

- **STEP 2:** Complete the *Three-Day Bladder Chart & Seven-Day Bowel Chart*
- **STEP 3:** Complete the *Continence Assessment Form And Care Plan*
- **STEP 4:** Complete the *Continence Care Summary*

Bladder and Bowel Symptoms that Warrant Further Attention

Although incontinence is not a life-threatening condition, it may be a sign of an underlying problem or health condition.

To assist you to identify persons who require further assessment, the *Continence Resources for Aged Care: User Guide* include a number of triggers to prompt a further level of assessment. Typically, the triggers advise notifying an RN in the first instance. The RN should have the requisite knowledge and skill to undertake a further assessment and to seek advice or medical intervention.

Abnormal bladder symptoms	
Voiding less than 3 times during day	If the person has difficulty voiding and/or voids infrequently, this may indicate a prostate problem (in men) or a neurological problem that results in incomplete bladder emptying. The symptom should be considered in relation to other symptoms (i.e. a sensation of incomplete bladder emptying etc.). Involving a Nurse Continence Specialist and/or a medical assessment may be appropriate.
Voiding more than 8 times during the day	If the person voids frequently during the day and/ or night, this may indicate an underlying health problem that requires attention, or it may be the result of medication. The symptom should be considered in relation to other symptoms (i.e. urgency, urge incontinence, symptoms of UTI, etc.). Involving a Nurse Continence Specialist and/or a medical assessment may be appropriate.
Voiding more than 2 times during the night	
The use of a urinary catheter	Persons with indwelling urinary catheters are at high risk for developing a catheter-associated urinary tract infection. It is important to develop a catheter care plan that minimises catheter-related problems. Involving a Nurse Continence Specialist and a medical assessment may be warranted. The catheter should not be removed unless it is clear that it is safe to do so and that the person will be able to independently void. Catheters should be avoided for continence management unless there is a clear benefit to the person.

Abnormal findings on urinalysis	
Glucose	The presence of glucose in the urine is a potential indicator of diabetes mellitus. If diabetes is suspected, the person should be referred to the Doctor for further investigation.
Bilirubin	Urine does not usually contain bilirubin. Any bilirubin found in the urine is conjugated bilirubin because unconjugated bilirubin cannot pass through the glomerulus. An elevated urine bilirubin may indicate biliary obstruction or liver disease. It should be brought to the attention of the Doctor.
Ketones	Ketones in urine are an abnormal finding. It may indicate the breakdown of fat, which is commonly encountered in uncontrolled diabetes. People on carbohydrate-free diet (high-protein weight loss diets), or who starve themselves for prolonged periods may show ketone in their urine. It should be brought to the attention of the Doctor.
Specific gravity Less than 1.000 Greater than 1.30	Specific gravity measures the kidney's ability to concentrate or dilute urine in relation to plasma. Because urine is a solution of minerals, salts, and compounds dissolved in water, the specific gravity is greater than 1.000. The more concentrated the urine, the higher the urine specific gravity. A low specific gravity may indicate renal disease and certain metabolic disorders (i.e. diabetes insipidus). The normal specific gravity range in urine is 1.000–1.030g/ml. Levels above or below this range should be brought to the attention of the Doctor.
Blood	Otherwise known as 'haematuria', blood in the urine can be visible to the naked eye or it may be microscopic. There are many possible causes of haematuria including urinary tract infection, inflammation/infection of the prostate, stones, and injury to any part of the urinary tract, excessive exercise, certain medications, (i.e. blood thinning agents), kidney disease and/or cancer of the kidney, prostate or bladder. If the person has haematuria, it should be brought to the attention of the Doctor.
pH Less than 5.0 Greater than 8.5	7 is the point of neutrality on the pH scale. The lower the pH, the greater the acidity of a solution; the higher the pH, the greater the alkalinity. Urine pH is an important screening test for the diagnosis of renal disease, respiratory disease and certain metabolic disorders. Depending on the person's acid-base status, the pH of urine may range from 5.0 to 8.5. Levels above or below this range should be brought to the attention of the Doctor.
Protein	Healthy kidneys limit the protein permeability of the glomerular capillaries, but diseased kidneys allow more protein to be filtered, so the presence of protein in urine (proteinuria) of more than 150 mg per day (10 to 20 mg per dL) is suggestive of renal disease. The presence of protein in the urine should be brought to the attention of the Doctor.
Urobilinogen	Normally present in the urine in small quantity. Less than 1% of urobilinogen is passed by the kidneys and the remainder is excreted in the faeces or transported back to the liver and converted into bile. Raised levels may be due to: Cirrhosis, hepatitis, hepatic necrosis, haemolytic and pernicious anaemia and malaria.
Nitrates	Under normal conditions, urine is not sterile and can contain bacteria, viruses and fungi. The presence of nitrates should be brought to the attention of the Doctor.
Leukocytes	The presence of leukocytes in urine is suggestive of a urinary tract infection. This should be brought to the attention of the Doctor.

Abnormal bowel symptoms	
Bowel motions less than 3 times per week or more than 3 times a day	Healthy bowel elimination is primarily characterised by regular bowel movements, a soft, formed stool and a stool that is easy to pass (i.e. no straining). The person may require increased fibre, fluid, activity or aperients to achieve this. People vary widely in how frequently they use their bowels (i.e. from 3 times per day to 3 times a week). If a person has less than 3 bowel movements in a week, and if the stool is hard and difficult to pass, this is a sign of constipation.
Pain and/or discomfort when using bowels	Pain/discomfort during defecation is not normal and should be investigated. It may indicate an underlying pathology. Involving a Nurse Continence Specialist and a medical assessment may be warranted.
Straining to use bowels	Some straining to use bowels is normal. Excessive straining indicates constipation and/ or an underlying pathology (i.e. neuropathic damage). Keep in mind that people with neurological disorders may have difficulty in achieving abdominal pressure that facilitates bowel clearance and may require a medically prescribed specialised intervention.
Bleeding when using bowels	Bleeding during defecation is not normal. It may indicate haemorrhoids or other underlying pathology. Involving a Nurse Continence Specialist and a medical assessment may be warranted.
Hard, dry bowel motions	Bowel motions should be soft and formed. Refer to the Bristol Stool Chart for assistance in differentiating between a healthy and unhealthy bowel motion. There are numerous factors that result in motions that are too hard (i.e. medication side effects, inadequate fluid, fibre or exercise) or in motions that are too loose (i.e. diet, irritable bowel syndrome, gastroenteritis, medication side effects etc.).
Very loose bowel motions	

Medications that May Affect Bladder and Bowel Function

Many people take either prescribed or over-the-counter medications (including aperients). Although medications are important for managing specific conditions, many have side effects that can affect bladder and/or bowel function.

For example, aperients are the most common cause of faecal incontinence in residential aged care homes. Similarly, diuretics (commonly used to manage chronic heart conditions) give people a strong sensation of urinary urgency that prompts them to rush to the toilet. During its peak effect, diuretics also give people a sense of wanting to pass urine frequently. It is important to inform the person's Doctor of any possible side effects so that their medication can be reviewed.

Table 3 lists medications that commonly affect bladder and/or bowel function. Many medications are prescribed to treat a person's medical condition and should not be altered. Inform the person's Doctor if you suspect the medications are causing or contributing to the person's bladder or bowel symptoms.

Table 3 Medications that commonly affect bladder and/or bowel function

Medication type	Example/s	Effect on bladder and/ or bowel function
Alpha-agonists	Pseudoephedrine (Sudafed)	Found in many nasal decongestants. Can cause voiding difficulties in men.
Anticholinesterase	Donepezil (Aricept) Galantamine (Reminyl) Rivastigmine (Exelon)	Management of dementia. Can contribute to urinary incontinence due to relaxation of the bladder sphincter and faecal incontinence due to diarrhoea.
Anti-hypertensives ▶ Alpha-adrenergic blockers ▶ Calcium channel blockers	Prazosin (Minipress)	Prescribed for the management of hypertension. Alpha-adrenergic blockers can cause increased urinary leakage.
	Nifedipine Lercanidipine	Calcium channel blockers can lead to urinary frequency and increased need to pass urine at night.
Antimuscarinic medications, or anticholinergics	Hyoscine (Buscopan)	Used to treat detrusor overactivity/ overactive bladder (not commonly used)
	Oxybutinin (Ditropan)	An anti-spasmodic that is sometimes used to manage bladder hyperactivity.
	Vesicare (Solifenacin)	A muscarinic receptor antagonist that reduces spasms of the bladder muscles and is used to treat the symptoms of overactive bladder such as incontinence, urinary frequency, and urgency.
	Betmiga (Mirabegron)	Symptomatic treatment of urgency, increased micturition frequency and/or urgency incontinence in patients with overactive bladder (OAB) syndrome.
		These medications can cause voiding difficulties and may contribute to constipation.
Antimuscarinic side effects ▶ Antihistamines ▶ Tricyclic antidepressants	Promethazine (Phenergan) Amitriptyline (Endep)	Used to treat allergies, motion sickness. For management of depression. Both can decrease awareness of the need to pass urine. Tricyclic antidepressants can also cause voiding difficulties.
Antipsychotics	Haloperidol Clozapine Resperidone Olanzapine	For the management of psychotic illnesses such as schizophrenia. Causes diabetes insipidus (frequent urination).
Aperients	Coloxyl with Senna Lactulose Movicol	There are many types of aperients to soften the stool and make it easier to pass. If overused, they can result in loose stool faecal urgency, frequency and faecal incontinence.
Benzodiazepines	Temazepam Diazepam Oxazepam	Used for sedation, i.e. management of insomnia. Contributes to decreased awareness of the need to pass urine, and impaired mobility.
Cytotoxics	Cyclophosphamide	For the treatment of cancers. Can result in a condition called Haemorrhagic Cystitis-inflammation of the Bladder leading to haemorrhage.
Diuretics	Frusemide (Lasix) Spironolactone	Encourages urine excretion. Some persons may experience urinary urgency, frequency and/or incontinence.
Homeopathic medication	St John's Wort	Treatment of depression. Has been associated with voiding difficulties.
Muscle relaxants	Baclofen	Used to manage muscle spasm in conditions such as Multiple Sclerosis or Spinal Cord Injury. It causes relaxation that can often affect the pelvic floor muscles, therefore contributing to incontinence.
Opiate, Opioid and Narcotic analgesia	Morphine Panadeine Forte Oxycontin	Used to treat moderate to severe pain. Can cause sedation, voiding difficulties and contribute to constipation.

Glossary

Term	Definition
Aperient	A laxative, either in the form of a medicine or a food, which has the effect of moving the bowels, or aiding digestion and preventing constipation.
Bowel management program	A bowel management program helps a person achieve bowel elimination that meets their needs and preferences. It may include strategies or interventions to prevent or treat bowel problems.
Bristol Stool Chart	An assessment guide designed to help determine the consistency or form of the stool.
Constipation	Complaint that bowel movements are infrequent and/ or incomplete and/or there is a need for frequent straining or manual assistance to defecate. (Rome IV Criteria) (ICS).
Dehydration	Dehydration occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and electrolytes to carry out its normal functions.
Diarrhoea	Defined as having three or more loose or liquid stools per day.
Dietary fibre	The parts of plants or their extracts that do not get digested and absorbed by the small bowel.
Enuresis	Complaint of involuntary urinary loss which occurs during sleep (ICS).
Faecal impaction	Impaction of faeces or stools is accompanied by a reduced sensory urge to defecate. The typical presenting symptoms include abdominal pain and distention, nausea, vomiting, and anorexia. In older adults, diarrhoea and faecal incontinence are common symptoms.
Faecal incontinence	The involuntary loss of liquid or solid stools that is a social or hygienic problem
Incontinence	The complaint of involuntary loss of urine.
Incontinence-associated dermatitis (IAD)	IAD describes the skin damage associated with exposure to urine or stool.
Incontinence products	Available to help people maintain social continence. They include products to help with toileting, with containing urinary or faecal incontinence, and/or managing urinary retention.
Individualised Toileting Assistance Program	Suitable for a person with a predictable (regular) voiding pattern. It involves: (i) identifying the person's usual voiding pattern and (ii) verbally prompting or physically assisting them, or both, to use the toilet prior to the predicted or anticipated voiding time.

Term	Definition
Neurological disorder	Diseases of the central and peripheral nervous system. These disorders include, but are not limited to: Dementia, Delirium, Depression, Stroke, Spinal cord injury, Parkinson's disease, Multiple Sclerosis and Normal pressure hydrocephalus.
Partnership-centred care	The health professional, the client and their family or carer are partners in all matters relevant to the client's care.
Perineum	Area between the posterior part of the external genitalia and the anus.
pH scale	Measures how acidic or alkaline a substance is. The scale range is from 0–14.
Polypharmacy	Simultaneous use of multiple medications to treat coexisting medical conditions which could result in adverse drug interactions.
Representative	May be a person nominated by the person as their spokesperson or advocate. They may or may not have formal delegated decision-making power ('power of attorney'), or be a guardian appointed by a tribunal.
RN	Registered Nurse.
Social continence	Otherwise known as 'contained incontinence' or 'managed incontinence' is incontinence that is successfully managed with incontinence products.
Specialised intervention/s	Some people, particularly those with a neurological disorder require a medically prescribed specialised intervention or technique to empty their bowel and/or bladder.
Timed Toileting Assistance Program	Relies on carers offering verbal prompts or physical assistance (or both) to a person to use the toilet at predetermined fixed voiding intervals, such as every two to four hours, regardless of whether the person has an urge to void or not.
Urinary frequency	The complaint by the person that they need to pass urine too often.
Urinary incontinence	The complaint of any involuntary loss of urine.
Urinary tract infection	Urinary tract infections (UTIs) can occur when bacteria enter and infect the urinary tract. A person may or may not have symptoms.
Urinary urgency	The complaint of a sudden compelling desire to pass urine, which is difficult to defer.
Incontinence associated with Urinary Retention (Urinary retention)	Associated with urine leakage from an already over-full bladder resulting from an obstruction.
Voiding	Passing urine.

Bibliography

Abrams P, Cardoza L, Fall M, Griffith D, Rosier P, Ulmsten U, van Kerrebroeck P, Victor A, Wein A. (2002). The Standardisation of terminology of lower urinary tract function: Report from the Standardisation Sub-committee of the International Continence Society. Neurourology and Urodynamics 21:167-178.

Australian Government Australian Aged Care Quality Agency. (2014). Results and Processes Guide. Viewed 29 November 2016 from: aacqa.gov.au/for-providers/residential-aged-care/resources/other-resources/copy_of_Resultsandprocesses.pdf

Australian Government. Quality of Care Principles 2014. Viewed 1 December 2016 from: legislation.gov.au/Details/F2014L00830

Australian Nursing and Midwifery Federation (May 2016). Nursing Education: Enrolled Nurse. ANMF Policy. Viewed 7 December 2016 from: anmf.org.au/documents/policies/P_Nursing_education_EN.pdf

Centers for Disease Control and Prevention (2015). Urinary Tract Infection. Viewed 12 December 2016 from: cdc.gov/getsmart/community/for-patients/common-illnesses/uti.html#

Colling J, Ouslander J, Hadley BJ, Eisch J, Campbell EJ (1992). The effects of patterned urge-response toileting (PURT) on urinary incontinence among nursing home residents. Journal of the American Geriatric Society. 1992 Feb;40(2):135-41.

Cottenden A, Bliss DZ, Buckley B, Fader M, Gartley C, Hayder D, Ostaszkiewicz J, Wilde M. (2013). Management using Continence Products. In Abrams P, Cardozo L, Khoury S, Wein A. (Eds.), Incontinence: 5th International Consultation on Incontinence. Paris, Feb. 2012. ICUD-EAU 2013

eTG Complete Therapeutic Guidelines. Viewed 7 December 2016 from: tgldcdp.tg.org.au/etgcomplete

Gray M. (2003). The importance of screening, assessing, and managing urinary incontinence in primary care. J Am Acad Nurse Pract. 15(3):102-7.

Gray M, Bliss DZ, Doughty DB, Ermer-Seltun J, Kennedy-Evans KL, Palmer MH. (2007). Incontinence-associated dermatitis: a consensus. Journal of Wound, Ostomy, & Continence Nursing. 34(1):45-54

Heaton, K W & Lewis, S J 1997, 'Resource form scale as a useful guide to intestinal transit time'. Scandinavian Journal of Gastroenterology, vol.32, no.9, pp.920–924. Viewed 2 March 2007.

Glossary of Terms. International Continence Society. Viewed 10 May 2019 from: ics.org/glossary

Lukacz ES, Sampselle C, Gray M, MacDiarmid S, Rosenberg M, Ellsworth P, Palmer MH. (2011). A healthy bladder: a consensus statement. International Journal of Clinical Practice. 65(10):1026-1036. 1026 doi: 10.1111/j.1742-1241.2011.02763.x

Mayo Foundation for Medical Education and Research. Patient Care & Health Information. Diseases and Conditions. Viewed 14 December 2016 from: mayoclinic.org/diseases-conditions

Milsom I, Altman D, Cartwright R, Lapitan MC, Nelson R, Sillén U, Tikkinen K. (2013). Epidemiology of Urinary Incontinence (UI) and other Lower Urinary Tract Symptoms (LUTS), Pelvic Organ Prolapse (POP) and Anal Incontinence (AI).

In Abrams P, Cardozo L, Khoury S, Wein A. (Eds.), Incontinence: 5th International Consultation on Incontinence. Paris, Feb, 2012. ICUD-EAU 2013

National Health and Medical Research Council and the New Zealand Ministry of Health (2006 – updated 2014). Nutrient Reference Values for Australia and New Zealand, including Recommended Dietary Intakes. Viewed 14 December from: nrv.gov.au/nutrients/dietary-fibre

Norton C, Whitehead WE, Blizz DZ, Metsola P, Tries J. (2005). Conservative and pharmacological management of faecal incontinence in adults. Int Incontinence Soc.1521-1563.

Ostaszkiewicz J, Eustice S, Roe B, Thomas LH, French B, Islam T, O'Connell B, Cody JD. Toileting assistance programmes for the management of urinary incontinence in adults. [Protocol]. Cochrane Database of Systematic Reviews 2013, Issue 6. Art. No.: CD010589. doi: 10.1002/14651858.CD010589

O'Connell B, Ostaszkiewicz J, Hawkins M. (2011). A suite of evidence-based continence assessment resources for residential aged care. Australasian Journal on Ageing. 30(1):27-32

Ostaszkiewicz J, O'Connell B, Dunning T. (2012). Residents' perspectives on urinary incontinence: A review of literature. Scandinavian Journal of Caring Sciences. 26(4):761-72.

National Institute for Labour Studies. (2013). National Aged Care Workforce Census and Survey. King D, Mavromaras K, Wei Z, Smith L, Macaitis K, Moskos M. Viewed 16 July 2016 from: flinders.edu.au/sabs/nils/research/completed-projects/national-aged-care-workforce-census-&-survey-2011.cfm

Nursing Outcomes Classification (NOC), 3rd ed. Outcome Labels and Definitions. Viewed 12 December 2016 from: rncasemanager.com/articles/NursingOutcomesClassificationLabelsDefinitions.pdf

Paterson J, Ostaszkiewicz J, Suyasa IG, Skelly J, Bellefeuille L. (2016). Development and Validation of the Role Profile of the Nurse Continence Specialist: A Project of the International Continence Society. Journal of Wound, Ostomy and Continence Nursing. 43(6):641-647

Staskin D & Kelleher C. et al. (2012). Initial Assessment of urinary incontinence in adult male and female patients (5A) and Patient-reported outcome assessment (5B). In Abrams P, Cardozo L, Khoury S, Wein A. (Eds.), Incontinence: 5th International Consultation on Incontinence. Paris, Feb. 2012. ICUD-EAU 2013

The Nursing and Midwifery Board of Australia. (2016a). Enrolled nurse standards for practice. Viewed 7 December 2016 from: nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

The Nursing and Midwifery Board of Australia. (2016b). Registered nurse standards for practice. Viewed 7 December 2016 from: nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

University of Western Sydney. (2009). Decision-making frameworks in advanced dementia: Links to improved care project. Supporting Information. Viewed 12 December 2016 from: uws.edu.au/__data/assets/pdf_file/0019/76240/Bowel_Management_Supporting_Information.pdf

Van Kerrebroeck P, Abrams P, Chaikin D, et al. The standardization of terminology in nocturia: report from the standardization subcommittee of the International Continence Society. BJU Int 2002;90 (Suppl 3):11-5et al., 2002)

Wagg AS, Kung Chew L, Kirschner-Hermanns R, Kuchel GA, Johnson 2nd T, Ostaszkiewicz J, Markland A, Palmer MH, Szonyi G. (2013). Incontinence in the Frail Elderly.

In Abrams P, Cardozo L, Khoury S, Wein A. (Eds.), Incontinence: 5th International Consultation on Incontinence. Paris, Feb, 2012. ICUD-EAU 2013

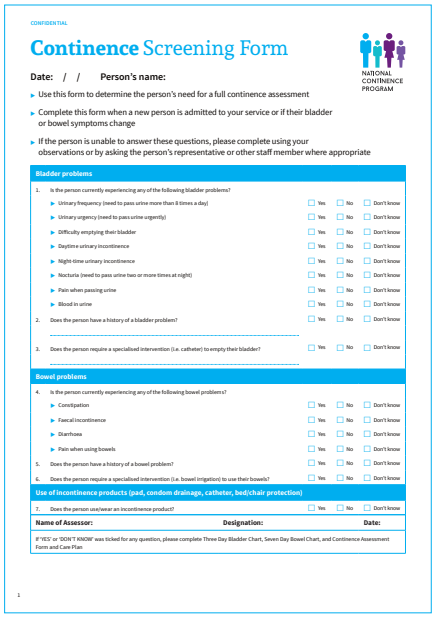
World Gastroenterology Organisation. (2010). Constipation: A global perspective. World Gastroenterology Organisation Global Guidelines

World Health Organisation (2016). What are neurological disorders? Viewed 12 December 2016 from: who.int/features/qa/55/en/

World Health Organisation (2013). Diarrhoeal disease Fact Sheet No 330. Viewed 12 December 2016 from: who.int/mediacentre/factsheets/fs330/en/

World Health Organisation (2016). International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10)-WHO Version for: 2016. apps.who.int/classifications/icd10/browse/2016/en#/F32.9

Appendix 1–7



CONFIDENTIAL

Continence Screening Form

NATIONAL CONTINENCE PROGRAM

Date: / / **Person's name:**

- Use this form to determine the person's need for a full continence assessment
- Complete this form when a new person is admitted to your service or if their bladder or bowel symptoms change
- If the person is unable to answer these questions, please complete using your observations or by asking the person's representative or other staff member where appropriate

Bladder problems

1. Is the person currently experiencing any of the following bladder problems?
   - Urinary frequency (need to pass urine more than 8 times a day) ☐ Yes ☐ No ☐ Don't know
   - Urinary urgency (need to pass urine urgently) ☐ Yes ☐ No ☐ Don't know
   - Difficulty emptying their bladder ☐ Yes ☐ No ☐ Don't know
   - Daytime urinary incontinence ☐ Yes ☐ No ☐ Don't know
   - Night-time urinary incontinence ☐ Yes ☐ No ☐ Don't know
   - Nocturia (need to pass urine two or more times at night) ☐ Yes ☐ No ☐ Don't know
   - Pain when passing urine ☐ Yes ☐ No ☐ Don't know
   - Blood in urine ☐ Yes ☐ No ☐ Don't know
2. Does the person have a history of a bladder problem? ☐ Yes ☐ No ☐ Don't know

   _____
3. Does the person require a specialised intervention (i.e. catheter) to empty their bladder? ☐ Yes ☐ No ☐ Don't know

   _____

Bowel problems

4. Is the person currently experiencing any of the following bowel problems?
   - Constipation ☐ Yes ☐ No ☐ Don't know
   - Faecal incontinence ☐ Yes ☐ No ☐ Don't know
   - Diarrhoea ☐ Yes ☐ No ☐ Don't know
   - Pain when using bowels ☐ Yes ☐ No ☐ Don't know
5. Does the person have a history of a bowel problem? ☐ Yes ☐ No ☐ Don't know
6. Does the person require a specialised intervention (i.e. bowel irrigation) to use their bowels? ☐ Yes ☐ No ☐ Don't know

Use of incontinence products (pad, condom drainage, catheter, bed/chair protection)

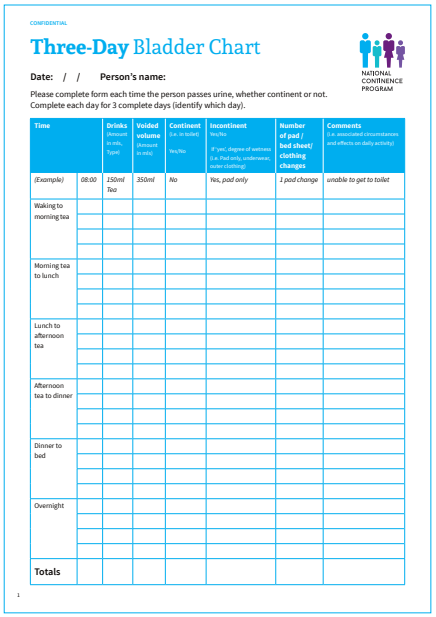
7. Does the person use/wear an incontinence product? ☐ Yes ☐ No ☐ Don't know

Name of Assessor: **Designation:** **Date:**

If 'YES' or 'DON'T KNOW' was ticked for any question, please complete Three Day Bladder Chart, Seven Day Bowel Chart, and Continence Assessment Form and Care Plan

1

Appendix 1



CONFIDENTIAL

Three-Day Bladder Chart

NATIONAL CONTINENCE PROGRAM

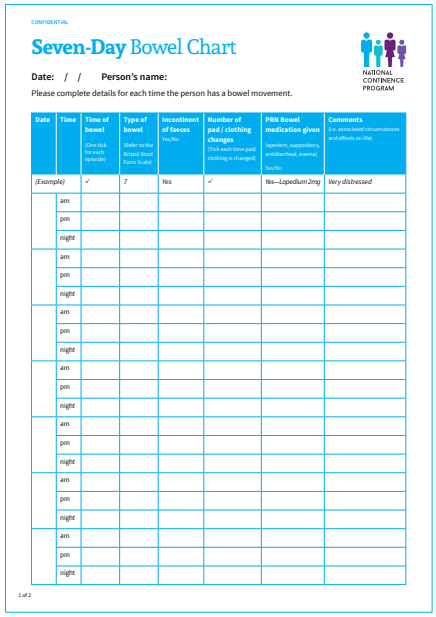
Date: / / **Person's name:**

Please complete form each time the person passes urine, whether continent or not. Complete each day for 3 complete days (identify which day).

Time		Drinks (Amount in mls, Type)	Voided volume (Amount in mls)	Continent (i.e. in toilet) Yes/No	Incontinent Yes/No If 'yes', degree of wetness (i.e. Pad only, underwear, outer clothing)	Number of pad / bed sheet/ clothing changes	Comments (i.e. associated circumstances and effects on daily activity)
(Example)	*08:00*	*150ml Tea*	*350ml*	*No*	*Yes, pad only*	*1 pad change*	*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							
Totals							

1

Appendix 2



CONFIDENTIAL

Seven-Day Bowel Chart

NATIONAL CONTINENCE PROGRAM

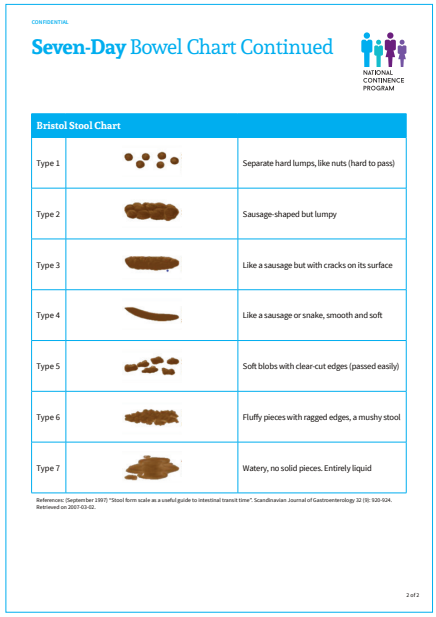
Date: / / **Person's name:**

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

Date	Time	Time of bowel (One tick for each episode)	Type of bowel (Refer to the Bristol Stool Form Scale)	Incontinent of faeces Yes/No	Number of pad / clothing changes (Tick each time pad/ clothing is changed)	PRN Bowel medication given (Aperient, suppository, antidiarrheal, enema) Yes/No	Comments (i.e. associated circumstances and effects on life)
(Example)		✓	*7*	*Yes*	✓	*Yes—Lopedium 2mg*	*Very distressed*
	am						
	pm						
	night						
	am						
	pm						
	night						
	am						
	pm						
	night						
	am						
	pm						
	night						
	am						
	pm						
	night						
	am						
	pm						
	night						
	am						
	pm						
	night						

1 of 2

Appendix 3



CONFIDENTIAL

Seven-Day Bowel Chart Continued

NATIONAL CONTINENCE PROGRAM

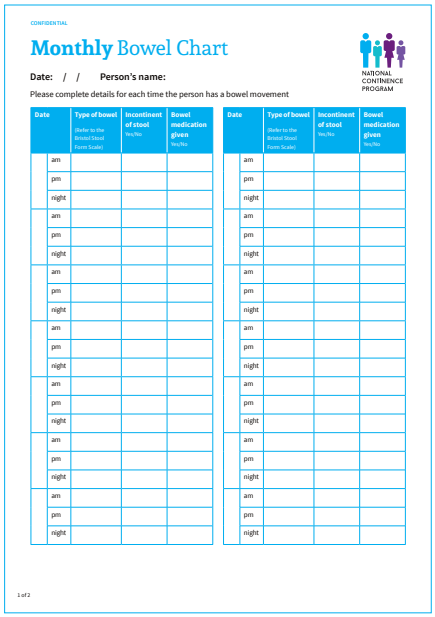
Bristol Stool Chart

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 easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely liquid

References: (September 1997) "Stool form scale as a useful guide to intestinal transit time". Scandinavian Journal of Gastroenterology 32 (9): 920-924. Retrieved on 2007-03-02.

2 of 2

Appendix 3 Continued



CONFIDENTIAL

Monthly Bowel Chart

NATIONAL CONTINENCE PROGRAM

Date: / / **Person's name:**

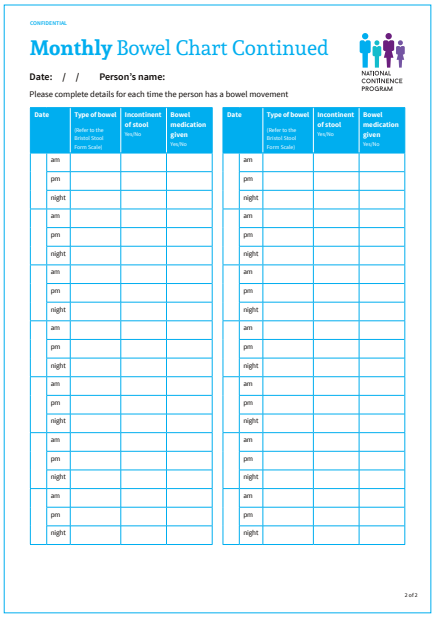
Please complete details for each time the person has a bowel movement

Date		Type of bowel (Refer to the Bristol Stool Form Scale)	Incontinent of stool Yes/No	Bowel medication given Yes/No
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			

Date		Type of bowel (Refer to the Bristol Stool Form Scale)	Incontinent of stool Yes/No	Bowel medication given Yes/No
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			

1 of 2

Appendix 4



CONFIDENTIAL

Monthly Bowel Chart Continued

NATIONAL CONTINENCE PROGRAM

Date: / / **Person's name:**

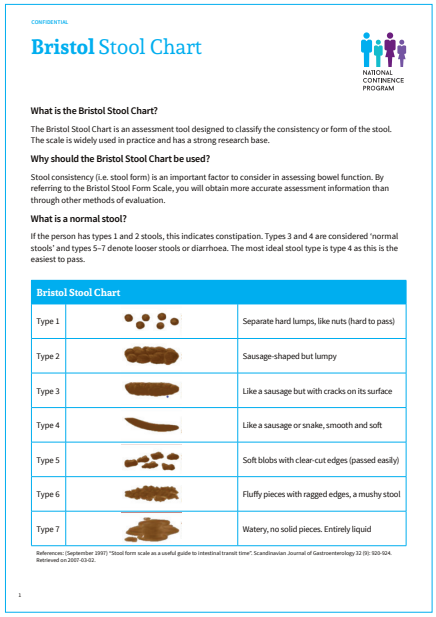
Please complete details for each time the person has a bowel movement

Date		Type of bowel (Refer to the Bristol Stool Form Scale)	Incontinent of stool Yes/No	Bowel medication given Yes/No
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			

Date		Type of bowel (Refer to the Bristol Stool Form Scale)	Incontinent of stool Yes/No	Bowel medication given Yes/No
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			
	am			
	pm			
	night			

2 of 2

Appendix 4 Continued



CONFIDENTIAL

Bristol Stool Chart

NATIONAL CONTINENCE PROGRAM

What is the Bristol Stool Chart?

The Bristol Stool Chart is an assessment tool designed to classify the consistency or form of the stool. The scale is widely used in practice and has a strong research base.

Why should the Bristol Stool Chart be used?

Stool consistency (i.e. stool form) is an important factor to consider in assessing bowel function. By referring to the Bristol Stool Form Scale, you will obtain more accurate assessment information than through other methods of evaluation.

What is a normal stool?

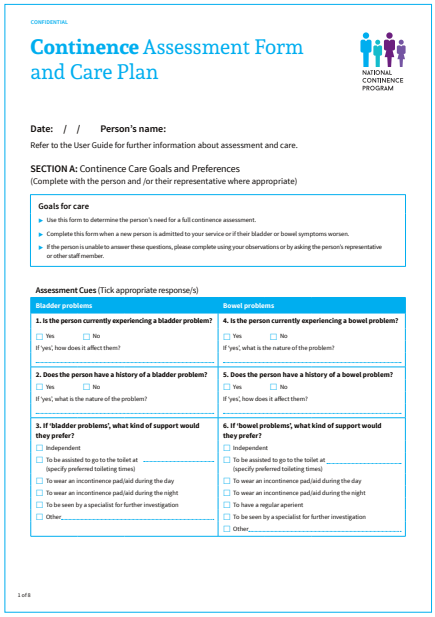
If the person has types 1 and 2 stools, this indicates constipation. Types 3 and 4 are considered 'normal stools' and types 5–7 denote looser stools or diarrhoea. The most ideal stool type is type 4 as this is the easiest to pass.

Bristol Stool Chart		
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 easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely liquid

References: (September 1997) "Stool form scale as a useful guide to intestinal transit time". Scandinavian Journal of Gastroenterology 32 (9): 920-924. Retrieved on 2007-03-02.

1

Appendix 5



CONFIDENTIAL

Continence Assessment Form and Care Plan

NATIONAL CONTINENCE PROGRAM

Date: / / **Person's name:**

Refer to the User Guide for further information about assessment and care.

SECTION A: Continence Care Goals and Preferences
(Complete with the person and /or their representative where appropriate)

Goals for care

- Use this form to determine the person's need for a full continence assessment.
- Complete this form when a new person is admitted to your service or if their bladder or bowel symptoms worsen.
- If the person is unable to answer these questions, please complete using your observations or by asking the person's representative or other staff member.

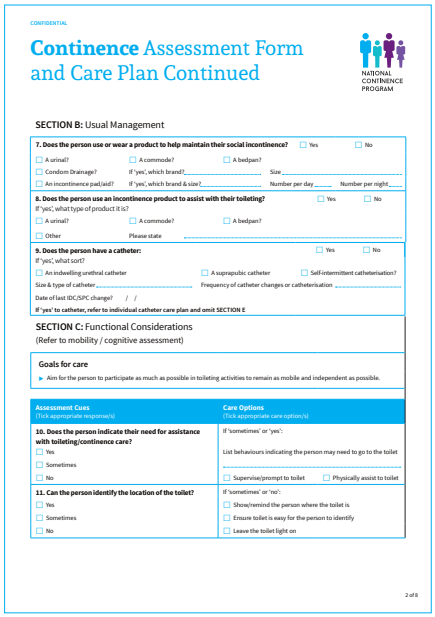
Assessment Cues (Tick appropriate response/s)

Bladder problems	Bowel problems
1. Is the person currently experiencing a bladder problem? ☐ Yes ☐ No If 'yes', how does it affect them?	**4. Is the person currently experiencing a bowel problem?** ☐ Yes ☐ No If 'yes', what is the nature of the problem?
2. Does the person have a history of a bladder problem? ☐ Yes ☐ No If 'yes', what is the nature of the problem?	**5. Does the person have a history of a bowel problem?** ☐ Yes ☐ No If 'yes', how does it affect them?
3. If 'bladder problems', what kind of support would they prefer? ☐ Independent ☐ To be assisted to go to the toilet at _____ (specify preferred toileting times) ☐ To wear an incontinence pad/aid during the day ☐ To wear an incontinence pad/aid during the night ☐ To be seen by a specialist for further investigation ☐ Other_____	**6. If 'bowel problems', what kind of support would they prefer?** ☐ Independent ☐ To be assisted to go to the toilet at _____ (specify preferred toileting times) ☐ To wear an incontinence pad/aid during the day ☐ To wear an incontinence pad/aid during the night ☐ To have a regular aperient ☐ To be seen by a specialist for further investigation ☐ Other_____

1 of 8

Appendix 6

Appendix 1–7 Continued



CONFIDENTIAL

Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

SECTION B: Usual Management

7. Does the person use or wear a product to help maintain their social incontinence? ☐ Yes ☐ No

☐ A urinal? ☐ A commode? ☐ A bedpan?
☐ Condom Drainage? If 'yes', which brand? Size
☐ An incontinence pad/aid? If 'yes', which brand & size? Number per day Number per night

8. Does the person use an incontinence product to assist with their toileting? ☐ Yes ☐ No
If 'yes', what type of product it is?
☐ A urinal? ☐ A commode? ☐ A bedpan?
☐ Other Please state

9. Does the person have a catheter: ☐ Yes ☐ No
If 'yes', what sort?
☐ An indwelling urethral catheter ☐ A suprapubic catheter ☐ Self-intermittent catheterisation?
Size & type of catheter Frequency of catheter changes or catheterisation
Date of last IDC/SPC change? / /
If 'yes' to catheter, refer to individual catheter care plan and omit SECTION E

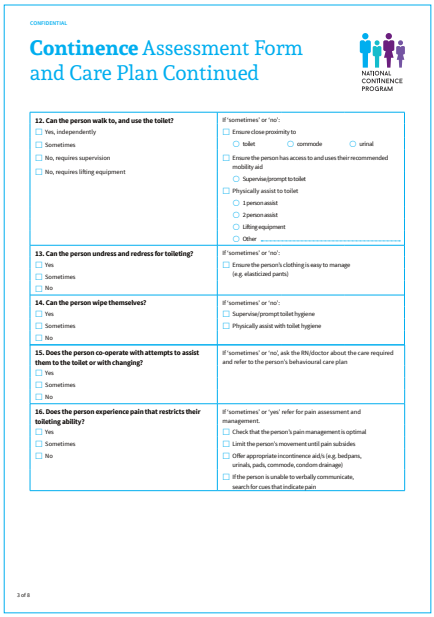
SECTION C: Functional Considerations
(Refer to mobility / cognitive assessment)

Goals for care
- Aim for the person to participate as much as possible in toileting activities to remain as mobile and independent as possible.

Assessment Cues (Tick appropriate response/s)	Care Options (Tick appropriate care option/s)
10. Does the person indicate their need for assistance with toileting/continence care? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'yes': List behaviours indicating the person may need to go to the toilet ☐ Supervise/prompt to toilet ☐ Physically assist to toilet
11. Can the person identify the location of the toilet? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'no': ☐ Show/remind the person where the toilet is ☐ Ensure toilet is easy for the person to identify ☐ Leave the toilet light on

2 of 8

Appendix 6 Continued



CONFIDENTIAL

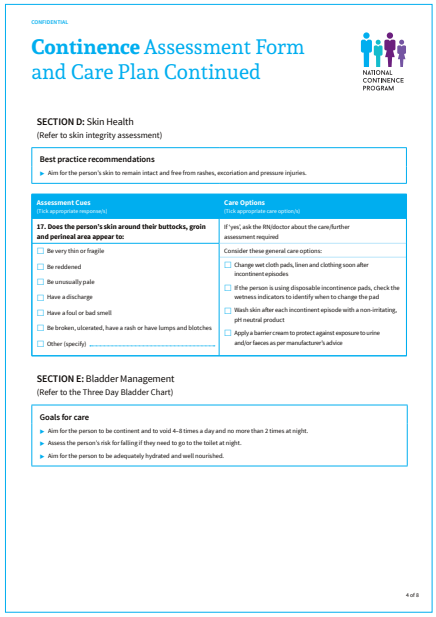
Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

12. Can the person walk to, and use the toilet? ☐ Yes, independently ☐ Sometimes ☐ No, requires supervision ☐ No, requires lifting equipment	If 'sometimes' or 'no': ☐ Ensure close proximity to ○ toilet ○ commode ○ urinal ☐ Ensure the person has access to and uses their recommended mobility aid ○ Supervise/prompt to toilet ☐ Physically assist to toilet ○ 1 person assist ○ 2 person assist ○ Lifting equipment ○ Other
13. Can the person undress and redress for toileting? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'no': ☐ Ensure the person's clothing is easy to manage (e.g. elasticised pants)
14. Can the person wipe themselves? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'no': ☐ Supervise/prompt toilet hygiene ☐ Physically assist with toilet hygiene
15. Does the person co-operate with attempts to assist them to the toilet or with changing? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'no', ask the RN/doctor about the care required and refer to the person's behavioural care plan
16. Does the person experience pain that restricts their toileting ability? ☐ Yes ☐ Sometimes ☐ No	If 'sometimes' or 'yes' refer for pain assessment and management. ☐ Check that the person's pain management is optimal ☐ Limit the person's movement until pain subsides ☐ Offer appropriate incontinence aid/s (e.g. bedpans, urinals, pads, commode, condom drainage) ☐ If the person is unable to verbally communicate, search for cues that indicate pain

3 of 8

Appendix 6 Continued



CONFIDENTIAL

Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

SECTION D: Skin Health
(Refer to skin integrity assessment)

Best practice recommendations
- Aim for the person's skin to remain intact and free from rashes, excoriation and pressure injuries.

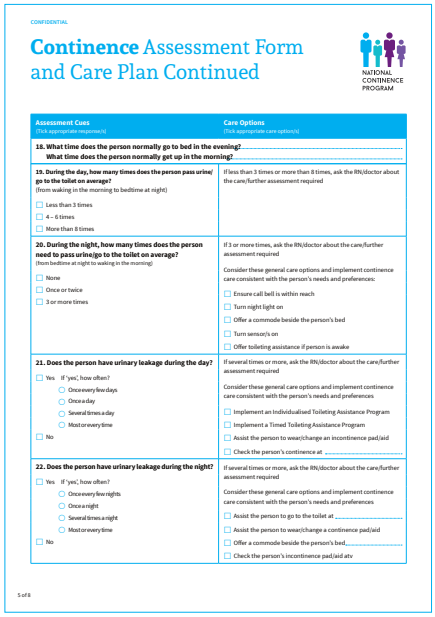
Assessment Cues (Tick appropriate response/s)	Care Options (Tick appropriate care option/s)
17. Does the person's skin around their buttocks, groin and perineal area appear to:	If 'yes', ask the RN/doctor about the care/further assessment required
☐ Be very thin or fragile ☐ Be reddened ☐ Be unusually pale ☐ Have a discharge ☐ Have a foul or bad smell ☐ Be broken, ulcerated, have a rash or have lumps and blotches ☐ Other (specify)	Consider these general care options: ☐ Change wet cloth pads, linen and clothing soon after incontinent episodes ☐ If the person is using disposable incontinence pads, check the wetness indicators to identify when to change the pad ☐ Wash skin after each incontinent episode with a non-irritating, pH neutral product ☐ Apply a barrier cream to protect against exposure to urine and/or faeces as per manufacturer's advice

SECTION E: Bladder Management
(Refer to the Three Day Bladder Chart)

Goals for care
- Aim for the person to be continent and to void 4–8 times a day and no more than 2 times at night.
- Assess the person's risk for falling if they need to go to the toilet at night.
- Aim for the person to be adequately hydrated and well nourished.

4 of 8

Appendix 6 Continued



CONFIDENTIAL

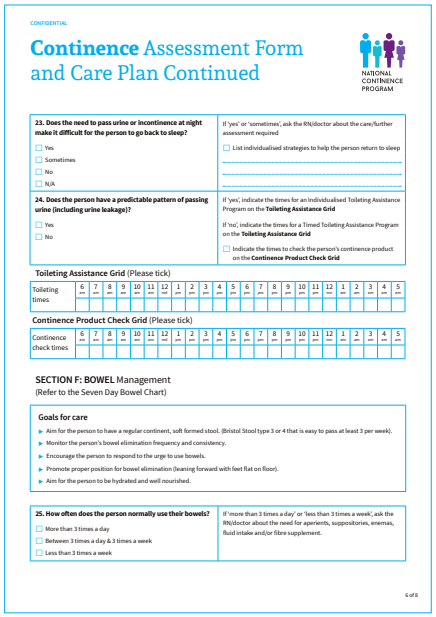
Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

Assessment Cues (Tick appropriate response/s)	Care Options (Tick appropriate care option/s)
18. What time does the person normally go to bed in the evening? **What time does the person normally get up in the morning?**	
19. During the day, how many times does the person pass urine/go to the toilet on average? (from waking in the morning to bedtime at night) ☐ Less than 3 times ☐ 4 – 6 times ☐ More than 8 times	If less than 3 times or more than 8 times, ask the RN/doctor about the care/further assessment required
20. During the night, how many times does the person need to pass urine/go to the toilet on average? (from bedtime at night to waking in the morning) ☐ None ☐ Once or twice ☐ 3 or more times	If 3 or more times, ask the RN/doctor about the care/further assessment required Consider these general care options and implement continence care consistent with the person's needs and preferences: ☐ Ensure call bell is within reach ☐ Turn night light on ☐ Offer a commode beside the person's bed ☐ Turn sensor/s on ☐ Offer toileting assistance if person is awake
21. Does the person have urinary leakage during the day? ☐ Yes If 'yes', how often? ○ Once every few days ○ Once a day ○ Several times a day ○ Most or every time ☐ No	If several times or more, ask the RN/doctor about the care/further assessment required Consider these general care options and implement continence care consistent with the person's needs and preferences ☐ Implement an Individualised Toileting Assistance Program ☐ Implement a Timed Toileting Assistance Program ☐ Assist the person to wear/change an incontinence pad/aid ☐ Check the person's continence at
22. Does the person have urinary leakage during the night? ☐ Yes If 'yes', how often? ○ Once every few nights ○ Once a night ○ Several times a night ○ Most or every time ☐ No	If several times or more, ask the RN/doctor about the care/further assessment required Consider these general care options and implement continence care consistent with the person's needs and preferences ☐ Assist the person to go to the toilet at ☐ Assist the person to wear/change a continence pad/aid ☐ Offer a commode beside the person's bed ☐ Check the person's incontinence pad/aid atv

5 of 8

Appendix 6 Continued



CONFIDENTIAL

Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

23. Does the need to pass urine or incontinence at night make it difficult for the person to go back to sleep?
☐ Yes ☐ Sometimes ☐ No ☐ N/A

If 'yes' or 'sometimes', ask the RN/doctor about the care/further assessment required
☐ List individualised strategies to help the person return to sleep

24. Does the person have a predictable pattern of passing urine (including urine leakage)?
☐ Yes ☐ No

If 'yes', indicate the times for an Individualised Toileting Assistance Program on the **Toileting Assistance Grid**

If 'no', indicate the times for a Timed Toileting Assistance Program on the **Toileting Assistance Grid**

☐ Indicate the times to check the person's continence product on the **Continence Product Check Grid**

Toileting Assistance Grid (Please tick)

Toileting times	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am

Continence Product Check Grid (Please tick)

Continence check times	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am

SECTION F: BOWEL Management
(Refer to the Seven Day Bowel Chart)

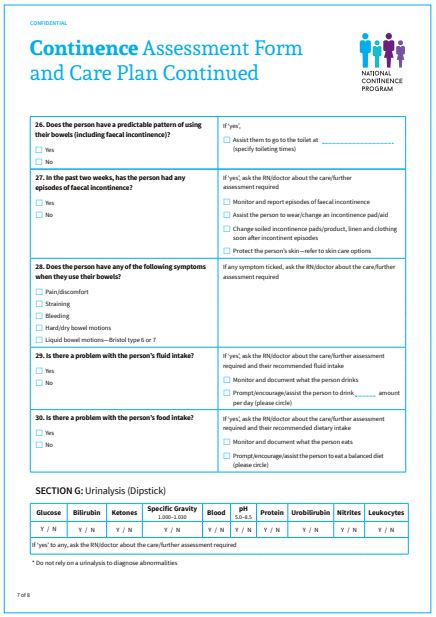
Goals for care
- Aim for the person to have a regular continent, soft formed stool. (Bristol Stool type 3 or 4 that is easy to pass at least 3 per week).
- Monitor the person's bowel elimination frequency and consistency.
- Encourage the person to respond to the urge to use bowels.
- Promote proper position for bowel elimination (leaning forward with feet flat on floor).
- Aim for the person to be hydrated and well nourished.

25. How often does the person normally use their bowels?
☐ More than 3 times a day
☐ Between 3 times a day & 3 times a week
☐ Less than 3 times a week

If 'more than 3 times a day' or 'less than 3 times a week', ask the RN/doctor about the need for aperients, suppositories, enemas, fluid intake and/or fibre supplement.

6 of 8

Appendix 6 Continued



CONFIDENTIAL

Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

26. Does the person have a predictable pattern of using their bowels (including faecal incontinence)?
☐ Yes ☐ No

If 'yes',
☐ Assist them to go to the toilet at _____ (specify toileting times)

27. In the past two weeks, has the person had any episodes of faecal incontinence?
☐ Yes ☐ No

If 'yes', ask the RN/doctor about the care/further assessment required
☐ Monitor and report episodes of faecal incontinence
☐ Assist the person to wear/change an incontinence pad/aid
☐ Change soiled incontinence pads/product, linen and clothing soon after incontinent episodes
☐ Protect the person's skin—refer to skin care options

28. Does the person have any of the following symptoms when they use their bowels?
☐ Pain/discomfort
☐ Straining
☐ Bleeding
☐ Hard/dry bowel motions
☐ Liquid bowel motions—Bristol type 6 or 7

If any symptom ticked, ask the RN/doctor about the care/further assessment required

29. Is there a problem with the person's fluid intake?
☐ Yes ☐ No

If 'yes', ask the RN/doctor about the care/further assessment required and their recommended fluid intake
☐ Monitor and document what the person drinks
☐ Prompt/encourage/assist the person to drink _____ amount per day (please circle)

30. Is there a problem with the person's food intake?
☐ Yes ☐ No

If 'yes', ask the RN/doctor about the care/further assessment required and their recommended dietary intake
☐ Monitor and document what the person eats
☐ Prompt/encourage/assist the person to eat a balanced diet (please circle)

SECTION G: Urinalysis (Dipstick)

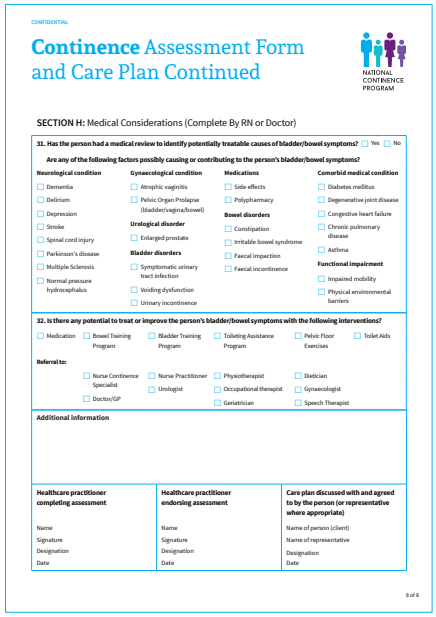
Glucose	Bilirubin	Ketones	Specific Gravity 1.000–1.030	Blood	pH 5.0–8.5	Protein	Urobilirubin	Nitrites	Leukocytes
Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

If 'yes' to any, ask the RN/doctor about the care/further assessment required

* Do not rely on a urinalysis to diagnose abnormalities

7 of 8

Appendix 6 Continued



CONFIDENTIAL

Continence Assessment Form and Care Plan Continued

NATIONAL CONTINENCE PROGRAM

SECTION H: Medical Considerations (Complete By RN or Doctor)

31. Has the person had a medical review to identify potentially treatable causes of bladder/bowel symptoms? ☐ Yes ☐ No

Are any of the following factors possibly causing or contributing to the person's bladder/bowel symptoms?

Neurological condition
☐ Dementia ☐ Delirium ☐ Depression ☐ Stroke ☐ Spinal cord injury ☐ Parkinson's disease ☐ Multiple Sclerosis ☐ Normal pressure hydrocephalus

Gynaecological condition
☐ Atrophic vaginitis ☐ Pelvic Organ Prolapse (bladder/vagina/bowel)

Urological disorder
☐ Enlarged prostate

Bladder disorders
☐ Symptomatic urinary tract infection ☐ Voiding dysfunction ☐ Urinary incontinence

Medications
☐ Side effects ☐ Polypharmacy

Bowel disorders
☐ Constipation ☐ Irritable bowel syndrome ☐ Faecal impaction ☐ Faecal incontinence

Comorbid medical condition
☐ Diabetes mellitus ☐ Degenerative joint disease ☐ Congestive heart failure ☐ Chronic pulmonary disease ☐ Asthma

Functional impairment
☐ Impaired mobility ☐ Physical environmental barriers

32. Is there any potential to treat or improve the person's bladder/bowel symptoms with the following interventions?
☐ Medication ☐ Bowel Training Program ☐ Bladder Training Program ☐ Toileting Assistance Program ☐ Pelvic Floor Exercises ☐ Toilet Aids

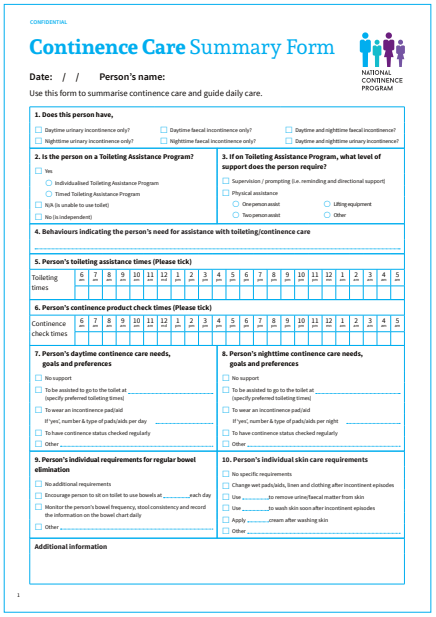
Referral to:
☐ Nurse Continence Specialist ☐ Doctor/GP ☐ Nurse Practitioner ☐ Urologist ☐ Physiotherapist ☐ Occupational therapist ☐ Geriatrician ☐ Dietician ☐ Gynaecologist ☐ Speech Therapist

Additional information

Healthcare practitioner completing assessment	Healthcare practitioner endorsing assessment	Care plan discussed with and agreed to by the person (or representative where appropriate)
Name Signature Designation Date	Name Signature Designation Date	Name of person (client) Name of representative Designation Date

8 of 8

Appendix 6 Continued



CONFIDENTIAL

Continence Care Summary Form

NATIONAL CONTINENCE PROGRAM

Date: / / Person's name:

Use this form to summarise continence care and guide daily care.

1. Does this person have,
☐ Daytime urinary incontinence only? ☐ Daytime faecal incontinence only? ☐ Daytime and nighttime faecal incontinence?
☐ Nighttime urinary incontinence only? ☐ Nighttime faecal incontinence only? ☐ Daytime and nighttime urinary incontinence?

2. Is the person on a Toileting Assistance Program?
☐ Yes
○ Individualised Toileting Assistance Program
○ Timed Toileting Assistance Program
☐ N/A (is unable to use toilet)
☐ No (is independent)

3. If on Toileting Assistance Program, what level of support does the person require?
☐ Supervision / prompting (i.e. reminding and directional support)
☐ Physical assistance
○ One person assist ○ Two person assist ○ Lifting equipment ○ Other

4. Behaviours indicating the person's need for assistance with toileting/continence care

5. Person's toileting assistance times (Please tick)

Toileting times	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am

6. Person's continence product check times (Please tick)

Continence check times	6 am	7 am	8 am	9 am	10 am	11 am	12 pm	1 pm	2 pm	3 pm	4 pm	5 pm	6 pm	7 pm	8 pm	9 pm	10 pm	11 pm	12 am	1 am	2 am	3 am	4 am	5 am

7. Person's daytime continence care needs, goals and preferences
☐ No support
☐ To be assisted to go to the toilet at _____ (specify preferred toileting times)
☐ To wear an incontinence pad/aid
If 'yes', number & type of pads/aids per day _____
☐ To have continence status checked regularly
☐ Other _____

8. Person's nighttime continence care needs, goals and preferences
☐ No support
☐ To be assisted to go to the toilet at _____ (specify preferred toileting times)
☐ To wear an incontinence pad/aid
If 'yes', number & type of pads/aids per night _____
☐ To have continence status checked regularly
☐ Other _____

9. Person's individual requirements for regular bowel elimination
☐ No additional requirements
☐ Encourage person to sit on toilet to use bowels at _____ each day
☐ Monitor the person's bowel frequency, stool consistency and record the information on the bowel chart daily
☐ Other _____

10. Person's individual skin care requirements
☐ No specific requirements
☐ Change wet pads/aids, linen and clothing after incontinent episodes
☐ Use _____ to remove urine/faecal matter from skin
☐ Use _____ to wash skin soon after incontinent episodes
☐ Apply _____ cream after washing skin
☐ Other _____

Additional information

1

Appendix 7

“ One person caring about another represents life’s greatest value. ”

Jim Rohn, author

Call the National Continence Helpline on FREECALL™ 1800 33 00 66

The helpline has a team of clinical advisors providing free, confidential advice, resources, details for local continence services, products and subsidies.

For more information, you can also visit:

www.continence.org.au
www.toiletmap.gov.au
www.bladderbowel.gov.au

Continence Foundation of Australia

Australian Government
Department of Health

CO1019 August 2019