Bladder & Bowel Continence Assessment

Date Assessment Initiated: _____
Information Source *(please circle)* – Resident (R), Family (F) _____, Chart (C), RN, RPN, PSW, other.

Addressograph

A. RELEVANT MEDICAL &/OR SURGICAL CONDITIONS
(From **R**esident, **F**amily, **C**hart)

- ☐ **Immobility Issues**
- ☐ Arthritis
- ☐ Other_____
- ☐ **Neurological Conditions**
- ☐ Stroke
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Spinal Cord injury
- ☐ Other_____
- ☐ **Medical Conditions**
- ☐ Diabetes
- ☐ Hypertension
- ☐ Hypothyroidism
- ☐ Heart Problems

Weight : _____ (kg)

- ☐ **Cognitive Problems**
- ☐ Dementia
- ☐ Other_____
- ☐ **Genito-Urinary (GU) Problems**
- ☐ Recurrent Urinary Tract Infections
- ☐ Previous G/U Surgery or Injury
- ☐ Prostate Problems
- ☐ Other_____
- ☐ **Gastro-Intestinal (GI) Problems**
- ☐ Chronic constipation
- ☐ Diverticular disease
- ☐ Hemorrhoids/fissures
- ☐ Previous colon surgery
- ☐ Irritable bowel syndrome
- ☐ Other_____

B. MEDICATIONS

See over	Y	N	Comments
Antacids with aluminum			
Analgesics/NSAIDS			
Anticholinergic/ Antispasmodic/ Anti-emetics			
Antidepressants			
Antihistamines			
Anti-hypertensives			
Anti-Parkinson agents			
Anti-psychotics			
Calcium Channel Blockers			
Cholinergic			
Diuretic			
Histamine-2 blockers			
Iron supplements			
Laxatives			
Narcotic analgesic			
Sedative/hypnotic			
Other			

C. URINARY CONTINENCE HISTORY

Urinary Incontinence Pattern	**Urinary Incontinence (UI) Frequency and Timing**	☐ No daytime UI ☐ Once a day or less ☐ 1-2 times a day ☐ 3 times a day or more ☐ Nighttime only ☐ Both day and night UI
	Urinary Incontinence (UI) Volume	☐ Entire bladder contents: large volume ☐ Small volume: leaks, drips, spurts ☐ Continuous bladder leakage ☐ Unable to determine
Urinary Incontinence History	**Onset**	☐ Sudden ☐ Gradual
	Duration	☐ < 6 months ☐ 6 months – 1 year ☐ > 1 year ☐ Unknown
	Symptoms over the past 6 months	☐ Worsening ☐ Stable ☐ Improving ☐ Fluctuating ☐ Unknown
Has a physician been consulted with above urinary problems? ☐ Yes ☐ No		

D: SYMPTOMS ASSOCIATED WITH URINARY INCONTINENCE

Type of Urinary Incontinence	Symptoms	Y	N	N/A	*Total number of "yes" answers
Stress UI	Leakage with cough, sneeze, physical activity				
	UI in small amounts (drops, spurts)				
	UI during daytime only				
	Fecal incontinence may be present				
Urge UI	Strong, uncontrolled urge prior to UI				
	UI moderate/large volume (gush)				
	Frequency of urination				
	Nocturia > 2 times				
	Nocturnal enuresis – bedwetting				
Overflow UI	Difficulty starting urine stream or straining to void				
	Weak or stop/go stream				
	Post-void dribbling				
	Prolonged voiding				
	Fullness after voiding				
	Suprapubic pressure and pain				
	Spurt of urine with movement				
Functional UI	Limited mobility				
	Requires assistance with toileting				
	Assistive aids/devices required (e.g., mechanical lift, 1-2 staff to assist, high seat, commode, support bars, hand rail, etc.)				
	Unable to get to the toilet on time/toilet too far				
	Can't hold urinal or sit on toilet				
	Can't reach/use call bell				
	Restraints or gerichair				
	Poor vision				
	Altered mental status				
	Pain poorly managed				
	Can't manage clothing				

*Follow interventions for the type of urinary incontinence that has the most "yes" answers. Take note that mixed incontinence (feature of both stress and urge incontinence) may be possible and interventions should focus on both types of incontinence. Refer to Physician and/or Nurse Continence Advisor for complex urinary incontinence issues.

Drugs that affect Bowel/Bladder Control

The purpose of this list is to give examples of drugs that can affect incontinence. It is not a comprehensive list.

Blood pressure/Heart
Anti-hypertensives
(Postural hypotension leads and functional urinary incontinence).

ACE inhibitors
- Benazepril
- Captopril
- Enalapril
- Fosinopril
- Lisinopril
- Quinapril
- Ramipril

ACE II inhibitors (ARB's)
- Candesartan
- Eprosartan
- Irbesartan
- Losartan
- Telmisartan
- Valsartan

Alpha Adreneurgics
- Clonidine

Diuretics
(Diruresis causes overflow incontinence)
- Acetazolamide
- Amiloride
- Bumetanide
- Chlorthalidone
- Hydrochlorothiazide
indapamide
- Metolazone
- Spironolactone

Calcium Channel Blockers
(Constipation, diarrhea)
- Amlodipine
- Diltiazem
- Felodipine
- Nifedipine
- Verapamil

Digestion/Excretion:
Antacids with aluminum
(laxative effect, can cause diarrhea or loose stools)

-Various Alumina compounds
-Aluminum Hydroxide
-Calcium Carbonate
-Calcium Carbonate and Magnesia
-Calcium Carbonate, Magnesia, and Simethicone
-Calcium and Magnesium Carbonates
-Magaldrate
-Magaldrate and Simethicone
-Magnesium Carbonate and Sodium Bicarbonate
-Magnesium Hydroxide

Laxatives
(Diarrhea, intestinal cramping, fecal incontinence)
- Polycarbophil
- Psyllium; Hydrophilic Mucilloid and Senna
- Lactulose
- Polyethylene glycol 3350
- Magnesium Citrate
- Magnesium Hydroxide (Milk of magnesia)
- Magnesium Sulfate
- Sodium Phosphate
- Milk of Magnesia & Mineral Oil
- Mineral Oil
- Bisacodyl
- Cascara Sagrada; and Aloe; and Bisacodyl
- Castor Oil
- Senna
- Sennosides
- Bisacodyl and Docusate
- Casanthranol and Docusate
- Danthron and Docusate
- Sennosides and Docusate
- Docusate

Mood/Behaviour:
Antidepressant
(Constipation, especially in elderly. Contributes to overflow and functional urinary incontinence. Problems with urination and loss of bladder control. Monoamine oxidase inhibitors (MAO's) can cause urinary retention.)

Tricyclic antidepressants
- Amitriptyline
- Clomipramine
- Desipramine
- Doxepin
- Imipramine
- Maprotiline (tetracyclic)
- Nortriptyline
Protriptyline
- Trimipramine

MAO Antidepressants
- Amoxapine
- Bupropion
- Citalopram
- Fluoxetine
- Fluvoxamine
- Mirtazapine
- Nefazadone
- Paroxetine
- Sertraline
- Trazodone
- Venlafaxine

Anti-psychotics
(Constipation, confusion, sedation, rigidity and immobility leading to overflow and functional urinary incontinence).

- Chlorpromazine
- Clozapine*
- Fluphenazine
- Haloperidol
- Loxapine
- Olanzapine*
- Perphenazine
- Pimozide
- Quetiapine*
- Risperidone*
- Thioridazine
- Trifluoperazine
*atypicals

Sedative/Hypnotic/ Barbiturate
(Can cause excessive sedation and decreased mobility in elderly people predisposing them to functional urinary incontinence. Not commonly used in long term care.)

- Butabarbital

Pain; Analgesics
Narcotic
Constipation and confusion leading to overflow and functional urinary incontinence.
- Codeine
- Hydrocodone
- Hydromorphone
- Levorphanol
- Meperidine
- Morphine
- Oxycodone
- Pentazocine
- Propoxyphene
- Nalbuphine

NSAIDS
-Urinary retention in elderly and or arthritic patients (on large doses)
Oral
- Diclofenac
- Diflunisal
- Etodolac
- Fenoprofen
- Floctafenine
- Ibuprofen
- Indomethacin
- Ketoprofen
- Meclofenamate
- Mefenamic Acid
- Nabumetone
- Naproxen
- Oxaprozin
- Piroxicam
- Sulindac
- Tenoxicam
- Tiaprofenic Acid
-Tolmetin

Other

Anticholinergic/ Antispasmodic/ Anti-emetics
(Constipation and urinary retention leading to overflow and functional urinary incontinence)
- Benztropine
- Oxybutynin
- Procyclidine
- Scopolamine
- Tolterodine
- Trihexyphenidyl

1st Generation Antihistamines
- Chorpheniramine
- Dephenhydramine
- Dimenhydrinate
- Hydroxyxine

Cholinergic
(Cause urge incontinence due to bladder relaxation. Not commonly used in long term care).
- Bethanechol

Anti-Parkinson agents
(Constipation, diarrhea)
- Levadopa
- Carbadopa
- Pergolide

Sources: AHCPR. 2006. Urinary Incontinence. http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat6.section.10079.; **Brigham & Women's Hospital.** 2004, Urinary incontinence http://www.brighamandwomens.org/medical/HandbookArticles/Urinaryincontinence.pdf.; **The Hartford Institute for Geriatric Nursing.** 2001. Urinary incontinence. http://www.hartfordign.org/publications/trythis/issue11.pdf.; **IC-5 Continence Project,** 2005, http://www.hospitalreport.ca/projects/QI_projects/IC5.html. **Rehabilitation Nursing Foundation.** 2002. Constipation. www.rehabnurse.org.; **RNAO.** 2005, Preventing Constipation; Prompting Continence. http://www.rnao.org/bestpractices. ; **Royal Women's Hospital**. 2005. Urinary incontinence, http://www.rwh.org.au/rwhcpg/womenshealth.cfm?doc_id=3661. ; **Singapore Ministry of Health**. 2003, http://www.moh.gov.sg/cmaweb/attachments/publication/Nursing_Management_of_Patients_with_Urinary_Incontinence_1-2003.pdf. **U.S. National Library of Medicine and U.S. National Institute of Health**. 2006. Drugs, supplements. < http://www.nlm.nih.gov/medlineplus/druginformation.html>.

Addressograph

D. BOWEL CONTINENCE HISTORY

Bowel Pattern	Comments
☐ Normal ☐ Constipation ☐ Diarrhea ☐ Fecal incontinence ☐ Irritable bowel pattern ☐ Impaction ☐ Laxative use/ suppositories/enemas – type and frequency: _____ ☐ Other remedies used to help with bowel movement: _____	Frequency: Usual time of day: Triggering meal: Nature & consistency: Other factors that have caused loss of bowel control:

Has a physician been consulted with above bowel problems? ☐ Yes ☐ No

E. MISCELLANEOUS RISK FACTORS

Caffeine use (coffee/tea/colas) ☐ Yes ☐ No	Amount: Frequency: Time of Day:
Alcohol use ☐ Yes ☐ No	Amount: Frequency: Time of Day:
Fiber intake ☐ Yes ☐ No	Amount: Frequency: Time of Day:
Exercise ☐ Yes ☐ No	Type of Activity: Frequency: Time of Day

G. TOILETING PATTERN AND PRODUCT USE

	Day	Evening	Night
Toileting pattern	☐ Toilet ☐ Commode ☐ Urinal ☐ Bed pan	☐ Toilet ☐ Commode ☐ Urinal ☐ Bed pan	☐ Toilet ☐ Commode ☐ Urinal ☐ Bed pan
Frequency of Toileting			
Identify type of pads, briefs or other incontinent products worn including size			

H. ABILITIES

Cognitive	Y	N	Comments
Aware of urge to void			
Aware of the urge to defecate			
Socially aware of appropriate place to pass urine/stool			
Able to find the toilet			
Able to understand reminders or prompts			
Aware of when wet and/or urine is being passed			
Motivated to be continent			
Preferences about toileting			
Aware of the risk factors related to not emptying bladder and bowel completely and regularly and the importance of doing so			

I. PHYSICAL ASSESSMENT

Voided Volume		**Residual Urine**	
Send for C & S	☐ Yes ☐ No	**Voiding Record Initiated**	☐ Yes ☐ No
Perineum	☐ Intact ☐ Redness ☐ Excoriation ☐ Other _____	**Bowel Record Initiated**	☐ Yes ☐ No
Unusual Urine Odour	☐ Yes ☐ No	**Discharge Post Voiding**	☐ Yes ☐ No
Unusual Stool Odour	☐ Yes ☐ No	**Discharge Post BM**	☐ Yes ☐ No

J. FLUID & FOOD INTAKE (Obtain from initial bladder and bowel record)

Fluid/food Intake in 24 hours	Type of fluid	Quantity (1 cup=250 mls)	Type of food	Quantity
Breakfast				
Mid am				
Lunch				
Mid pm				
Supper				
Evening				
Night				
Total				

K. SUMMARY – CONTINENCE STATUS

Bladder

☐ Continent

☐ Incontinent : ☐ Stress UI ☐ Urge UI ☐ Overflow UI ☐ Functional UI

☐ Care Plan Initiated/Updated ☐ Voiding Record Initiated

☐ Referral required:
☐ Dietitian ☐ Physician ☐ OT ☐ PT

☐ Treatment Options:
- ☐ Prompted Voiding
- ☐ Fluid Intake Changes
- ☐ Caffeine Reduction
- ☐ Intermittent Catheterization
- ☐ Bedside Commode
- ☐ Personal Hygiene
- ☐ Incontinent Product
- ☐ Other: _____

Bowel

☐ Continent

☐ Incontinent

☐ Care Plan Initiated/Updated

☐ Bowel Record Initiated

☐ Referral required:
☐ Dietitian ☐ Physician ☐ OT ☐ PT

Contributing Factors

- ☐ Urinary Tract Infection
- ☐ Constipation
- ☐ Weight
- ☐ Cognitive – Mini Mental Status Examination (MMSE) Score: ____
- ☐ Fluid Intake
- ☐ Medications
- ☐ Environmental Factors
- ☐ Caffeine Intake
- ☐ Alcohol Intake
- ☐ Mobility
- ☐ Other

L. CONTINENCE CARE PLAN

Problems Identified	Interventions

Date of Assessment: _____

Assessor: _____

Urinary Incontinence Types and Interventions (Adapted from: RNAO, 2005. Orientation Program for Nurses in Long-Term Care Workbook. Toronto, Canada: RNAO)

	Stress UI	**Urge UI**	**Overflow UI**	**Functional UI**
Cause	Failure to store	Failure to store	Failure to empty	Failure to store
Frequency	20% of all cases	50% of all cases	10% of all cases	20% of all cases
Symptoms	-Small amount of urine loss frequently when residents coughs, laughs, changes position -Wet during day -Dry at night, no distention	-Large amounts of urine loss frequently "can't get to bathroom in time" -Wet day and night -No distention	-Small amounts of urine loss frequently -Wet day and night -Distention	-Bladder and sphincter are normal -Wet day and night -No distention
Pathology	Weakness of sphincter	Result of neurological and/or urological disease	-Female: result of cystocele -Male: result of enlarged prostrate, fecal impaction	Other factors cause incontinence: -Drugs -Environment -Psychological
Prevalence	Mostly female	Both male and female	Both male and female	Both male and female
Treatments/ Interventions	-Medications (e.g., Premarin & Entex-LA) -Kegel exercises -Prompted voiding	-Medications (e.g., Ditropan & antibiotics) -Surgery -Bladder training routines -Toileting routines -Prompted voiding	-Medications (e.g., Prazosin & Proscar) -Surgery -Double voiding -Crede maneuver -Bowel maintenance program -Disimpaction	-Medications -Surgery -Environment -Mobility -Psychological -Prompted voiding

Critical Pathway for Urinary Incontinence (Stress, Urge, and Functional Types)
(© UNC-CH School of Medicine, Program on Aging & the Division of Social Services, State of North Carolina)

Nursing Diagnosis	**Assessment**	**Goals**	**Intervention**
Alteration in urinary elimination: urinary incontinence, -Stress -Urge -Functional	-History and physical exam to determine causes, contributing factors to UI. -Record voiding and incontinence pattern 3-day bladder diary. -Assess bladder symptoms. -Assess urine character, odour, colour. -Rule out urinary retention – Post Void Residual (PVR).	-Reduction or resolution of UI episodes. -Incontinence well managed to promote independence, comfort, quality of life. -Prevention of adverse sequela of UI.	Teach resident: -Toileting schedules. -Pelvic muscle exercises. -Urge control. -Appropriate selection and use of absorbent products. -Toileting devices. -Clothing adaptations. -Bowel management.
Alteration in urinary elimination: urinary retention	-Assess and document urinary retention. -Assess resident's skill in self-management of voiding and catheter use if indicated. -Monitor bladder diary to assess progress with self-care interventions for bladder emptying.	-Schedule of regular bladder emptying and fluid intake. -Utilization of voiding maneuvers and catheterization, as indicated. -Prevention and early recognition of UTI.	Teach resident: -Voiding maneuvers: Crede' and double voiding. -Intermittent catheterization. -UTI prevention. -Sign/Symptom of UTI.
Alteration in fluid volume: fluid volume deficit	-Assess fluid intake from bladder diary recorded for 3 days. -Calculate fluid intake goals based on body weight and activity. -Develop fluid hydration protocol.	-Fluid intake adequate for urine dilution, bladder and bowel function, metabolic needs. -Treatment plan is acceptable to resident.	-Teach resident to implement fluid management protocol to meet individual fluid goals.
Alteration in nutritional intake: bladder irritants	-Assess consumption of bladder irritants: caffeine, artificial sweeteners, carbonated drinks, alcohol, spicy foods, milk, acidic juices. -Assess preferences for substitutions for irritants.	-Elimination or titration of bladder irritants. -Substitution of non-irritating beverages of choice.	-Instruct resident on rationale for avoidance of bladder irritants. -Teach resident ways to reduce and eliminate bladder irritants. -Monitor for effect of elimination.
Alteration in bowel elimination: constipation or fecal impaction	-Assess bowel elimination pattern, fibre and fluid intake, activity, and bowel aides.	-Establish regular bowel schedule. -Establish adequate fluid and fibre intake. -Minimize, avoid use of laxatives or enemas. -Reinforce good hygiene-wiping front to back, change after UI.	-Teach resident bowel program with dietary and fluid adjustments and fibre supplementation. -Develop exercise program within capacity of resident. -Augment toileting with knee-chest position using footstool.
Knowledge deficit related to self-care strategies for bladder health promotion	-Assess baseline knowledge of UI and self-care strategies. -Teach self-care strategies to improve or restore continence and bowel function. -Teach early recognition of UI-related problems: UTI, dermatitis, fecal impaction, urinary retention. -Teach self-monitoring of medication for UI, therapeutic, side and adverse effects.	-Resident describes causes and contributing factors to UI and bowel dysfunction. -Resident demonstrates effective self-care behaviours for urinary and bowel function.	-Instruct resident about UI status and rationale for interventions. -Modify interventions to allow for resident to implement gradually. -Set short term goals. -Reinforce resident behaviours that are health-promoting.
Self-care deficit	-Assess need for skill training to promote independence in toileting, e.g., exercises or physical therapy. -Assess need for equipment to promote independence in toileting, e.g., bedside commode, urinal, external devices. -PT/OT consults to assess need for muscle strengthening/ADL skill training for ambulation, transfer, or use of devices.	-Adaptive equipment and devices are acceptable, feasible, and appropriate for resident's needs. -Resident achieves highest level of physical function with exercise and rehabilitation therapies. -Resident assisted to achieve maximum independence in toileting skills.	-Select and instruct resident in use of adaptive equipment or devices. -Counsel resident about personal goal-setting related to toileting and continence.
Alteration in skin integrity: urine contact dermatitis	-Assess skin integrity for inflammation, maceration, infection, abrasion, and breakdown. -Asses resident's usual hygiene pattern. -Assess absorbent product usage for adequacy and appropriateness.	-Skin remains intact. -Absorbent product usage is appropriate for amount and frequency of urine loss. -Absorbent product is acceptable to the resident.	-Individualize skin care. -Monitor for sign/symptom of yeast, urine dermatitis. -Barrier ointment for fecal incontinence.
Alteration in urinary elimination: urinary tract infection	-Assess for signs/symptoms of UTI. -Assess fluid intake and voiding pattern. -Assess intake and output. -Assess bowel pattern for impaction, constipation, fecal incontinence.	-Resident is free of UTI. -Early recognition of signs/symptoms of UTI and urosepsis. -Prompt treatment of UTI.	-Reinforce good hygiene. -Increase fluid intake to 2000 – 4000 a day. -Change pad after each UI episode. -Bowel management. -Vitamin C BID per MD order. -Cranberry juice 8-12 oz. daily. -Re-culture as indicated.