RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

Transdisciplinary Patient/Client Continence Assessment Tool

PERSONAL DATA Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
Date of Birth YYYY / MM / DD Age Gender ❑ Male ❑ Female		
INCONTINENCE HISTORY		
▸ Type ❑ Urinary Incontinence ❑ Fecal Incontinence ❑ Both ❑ Other		
▸ Onset ❑ Sudden ❑ Gradual		
▸ Duration ❑ < 6 months ❑ 6 months - 1 year ❑ 1-2 years ❑ 2-5 years ❑ > 5 years		
▸ Incontinence over the past 6 months ❑ Worsening ❑ Stable ❑ Improving ❑ Fluctuates		
▸ What do you think has caused the problem?		
▸ How often do you go to the toilet during the day?		
▸ Do you have any accidents during the waking hours? ❑ Yes ❑ No If Yes, how often? ❑ < 1 day ❑ 1 per day ❑ 1 per week ❑ 2-6 per week ❑ 1 per month ❑ Not known		
▸ Does urine or feces ❑ Soil/wet underwear only ❑ Soil outer clothing ❑ Run down your legs ❑ Pool on the floor ❑ Remain within containment product		
▸ Is the amount ❑ Consistent ❑ Variable		
▸ Does the need to go wake you up? ❑ Yes ❑ No		
▸ How often do you go to the toilet after going to bed?		
▸ Do you have accidents at night? ❑ Yes ❑ No If Yes, how often? ❑ 1 per night ❑ >1 per day ❑ 1 per week ❑ 2-6 per week ❑ 1 per month ❑ Not known		
▸ How much leakage? ❑ Wets/soils incontinent product ❑ Wets/soils night attire ❑ Wets/soils bedding ❑ Additional soiling		
▸ Do you leak urine or feces with physical stress (I.e., Cough, laugh, sneeze, lift, jump)? ❑ Yes ❑ Yes, just after ❑ Occasionally ❑ Not known ❑ No		
▸ Do you have to rush to the bathroom when you feel the urge? ❑ Yes ❑ No ❑ Occasionally ❑ Not known		
▸ On average, how long can you hold on after feeling the first urge? ❑ Not at all ❑ < 5 minutes ❑ 5-15 minutes ❑ >15 minutes ❑ Varies ❑ Not known		

INCONTINENCE HISTORY — Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you feel that you completely empty your bladder when you pass urine? ❑ Yes ❑ No		
▸ Are you aware of the urge to void or move your bowels? ❑ Yes ❑ No ❑ Not known		
▸ Are you aware of passing urine? ❑ Yes ❑ No ❑ Not known		
▸ Are you aware when wet/soiled? ❑ Yes ❑ No ❑ Not known		
BLADDER		
▸ Do you have: 1. Hesitancy ❑ Yes ❑ No ❑ Not known 2. Straining/manual expression ❑ Yes ❑ No ❑ Not known 3. Poor stream ❑ Yes ❑ No ❑ Not known 4. Dysuria (difficult or painful urination) ❑ Yes ❑ No ❑ Not known 5. Post-micturition dribble ❑ Yes ❑ No ❑ Not known 6. Constant dribble ❑ Yes ❑ No ❑ Not known 7. Change in odour of urine in past 6 months ❑ Yes ❑ No ❑ Not known 8. Hematuria (blood in urine) ❑ Yes ❑ No ❑ Not known		
▸ What type of product is used for containment? (specify) How many are used every 24 hours?		
FLUID INTAKE		
▸ Do you restrict your fluids? ❑ Yes ❑ No ❑ Sometimes		
▸ How much do you drink in a day, including water? *(Describe in cups [1 cup = 250 mL])* Breakfast ______ cups Mid-morning ______ cups Lunch ______ cups Mid-day ______ cups Supper ______ cups Evening ______ cups DAILY TOTAL = ______ cups		
RISK BEHAVIOURS		
▸ Do you drink beverages containing caffeine? ❑ Yes ❑ No ______ cups per day		
▸ Do you drink any alcoholic beverages? ❑ Yes ❑ No ______ drinks per day		
BOWEL		
▸ What has been your bowel pattern in the last six months? ❑ Daily ❑ 2-3 times a day ❑ 3 times per week ❑ Other:		
▸ Is this a change from your previous normal pattern? ❑ Yes ❑ No If Yes, when did this occur?		
▸ Do you frequently have hard or difficult bowel movements? ❑ Yes ❑ No		
▸ Any detection of blood in your bowel movement? ❑ Yes ❑ No		
▸ Any pain with bowel movement? ❑ Yes ❑ No If Yes, describe:		

BOWEL Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you have hemorrhoids? ❑ Yes ❑ No		
▸ Is diet used to keep your bowels regular? ❑ Yes ❑ No		
▸ Indicate product(s) or procedure(s) used for regulation: 1. Laxatives ❑ Yes ❑ No 2. Suppositories ❑ Yes ❑ No 3. Enemas ❑ Yes ❑ No 4. Manual disimpaction ❑ Yes ❑ No 5. Other (specify) ❑ Yes ❑ No		
▸ Do you have loose bowel movements? ❑ Yes ❑ No If Yes, how often?		
▸ Do any foods contribute to loose stools? ❑ Yes ❑ No If Yes, which food(s)?		

MEDICAL HISTORY Scope of Practice | Continence Advisor | RN | RPN				
▸ **Previous Surgery**	**When**	**Comments**		
Trans Urethral Prostatectomy (TURP)				
Abdominal Hysterectomy				
Vaginal Hysterectomy				
Bladder Repair				
Abdominal Peritoneal Resection				
▸ **Medical Conditions**	**Onset**	**Comments**		
Stroke (CVA)				
Parkinson’s Disease				
Multiple Sclerosis				
Diabetes Mellitus				
Fractured Hip				
Urinary Tract Infection				
Cancer				
Glaucoma				
Renal Stones				
Dementia				
Arthritis				
Other (specify)				

MEDICAL HISTORY Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
Abilities Assessment		
Aware of urge to void ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Able to find the toilet ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Able to understand reminders or prompts ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Able to ask for assistance ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Able to remove clothing to toilet ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Able to sit on the toilet/ hold the urinal ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Motivated to be continent ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Socially aware of appropriate place to pass urine ❑ Yes ❑ No ❑ Occasionally ❑ Unable to answer		
Childbirth		
Have you experienced childbirth? ❑ Yes ❑ No If YES, total # of deliveries _______		
With your vaginal deliveries, did you have 1. Forceps ❑ Yes ❑ No		
2. Breech ❑ Yes ❑ No		
3. Posterior ❑ Yes ❑ No		
4. Tears ❑ Yes ❑ No		
5. Episiotomy ❑ Yes ❑ No		
6. Prolonged labour ❑ Yes ❑ No		
7. Heavy babies ❑ Yes ❑ No		
Caesarean section? ❑ Yes ❑ No		
Menopause? ❑ Yes Age __________		
Have you discussed your problem of incontinence with your family doctor? ❑ Yes ❑ No		
Have you had any previous treatment for incontinence? ❑ Yes ❑ No If YES, describe:		
MEDICATION REVIEW Scope of Practice | Continence Advisor | RN | RPN *REVIEW MAR (Medication Administration Record)*		
Any medication with the following actions: 1. Anticholinergic ❑ Yes ❑ No		
2. Cholinergic ❑ Yes ❑ No		
3. Diuretics ❑ Yes ❑ No		
4. Estrogen ❑ Yes ❑ No		
5. Sedative/Hypnotic ❑ Yes ❑ No		
6. Antidepressant ❑ Yes ❑ No		
7. Antispasmodic ❑ Yes ❑ No		
8. Antipsychotic ❑ Yes ❑ No		

PHYSICAL ASSESSMENT Scope of Practice | Continence Advisor	Initials / Designation	Date yyyy/mm/dd
▸ Perineal Skin ❑ Intact ❑ Redness ❑ Excoriation ❑ Other:		
▸ Personal Hygiene uses soap ❑ Yes ❑ No		
▸ Voided Volume =		
▸ Residual urine ❑ Yes ❑ No Volume = _______________ ❑ Catheterization ❑ Ultrasound Sent for culture/sensitivity? ❑ Yes ❑ No		
Female		
▸ Atrophic vaginal changes noted on visual inspection ❑ Yes ❑ no		
▸ Vaginal discharge ❑ Yes ❑ No If YES, swab sent ❑ Yes ❑ No Results:		
Cystocele ❑ Grade I – Small ❑ Grade II – Moderate ❑ Grade III – Beyond Introitus ❑ Absent ❑ Not assessed		
Rectocele ❑ Yes ❑ No		
Able to contract pelvic floor ❑ Yes ❑ No		
Circumvaginal muscle strength (Oxford Scale) ❑ Nil ❑ Flicker ❑ Weak ❑ Moderate ❑ Good ❑ Strong ❑ Not assessed		
Male Epispadias ❑ Yes ❑ No Hypospadias ❑ Yes ❑ No Retracted penis ❑ Yes ❑ No		
Rectal Examination Perianal sensation ❑ Present ❑ Reduced ❑ Absent Anal tone ❑ Present ❑ Reduced ❑ Absent		
CONTRIBUTING FACTORS		

CATEGORY	Initials / Designation	Date yyyy/mm/dd
❑ Stress ❑ Urge ❑ Stress/urge ❑ Overflow ❑ Functional ❑ Iatrogenic ❑ N/A ❑ Other:		
TREATMENT OPTIONS		
1. Prompted voiding ❑ Initiated ❑ N/A 2. Kegel pelvic floor excercises ❑ Initiated ❑ N/A 3. Urge suppression ❑ Initiated ❑ N/A 4. Fluid intake changes ❑ Initiated ❑ N/A 5. Caffeine reduction ❑ Initiated ❑ N/A 6. Intermittent catheterization (self/caregiver) ❑ Initiated ❑ N/A 7. Bedside commode ❑ Initiated ❑ N/A 8. Caregiver instruction ❑ Initiated ❑ N/A 9. Personal hygiene ❑ Initiated ❑ N/A 10. Incontinence product education ❑ Initiated ❑ N/A 11. Education about aids and appliances ❑ Initiated ❑ N/A 12. Other: ❑ Initiated ❑ N/A		
REFERRAL		
▸ Referral to:		

NOTES

SOAP LEGEND **S** = Subjective **O** = Objective **A** = Analysis **P** = Plan

Date	Time	Discipline	SOAP Notes

Acknowledgement

The Registered Nurses' Association of Ontario (RNAO) and the Nursing Best Practice Guidelines Program would like to acknowledge the following individuals and organizations for their contributions to the development of the *Transdisciplinary Patient/ Client Continence Assessment Tool.*

- **Barbara Cassel, RN, BScN, MN, GNC(C), NCA,** who developed this resource as an extension of her ongoing commitment to implementation of RNAO's Nursing Best Practice Guidelines.
- West Park Healthcare Centre, recipient of the RNAO Best Practice Spotlight Organization (BPSO) designation, recognizing an ongoing commitment to supporting, implementing and evaluating RNAO Best Practice Guidelines.
- The RNAO *Promoting Continence Using Prompted Voiding* development panel who developed the guideline on which this resource is based.

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Registered Nurses' Association of Ontario (2006). *Transdisciplinary Patient/Client Continence Assessment Tool.* Toronto, Canada: Registered Nurses' Association of Ontario.

The RNAO Nursing Best Practice Guidelines Program is funded by the Government of Ontario.