Outline of steps for carrying out a baseline continence assessment (level 1)

This reference sheet should be used in conjunction with the national community operations guideline for assessment, promotion and management of continence in adults 2019.

STEP 1: For adults presenting with bladder & bowel dysfunction the RN completes bladder & bowel assessment form. Obtain consent for data collection from client to have the assessment shared with other members of the MDT. Ensure privacy for patient during assessment.

During assessment detail any physical, sensory or intellectual disability and consider A, B,C below

A-Medical details

Record all medical, surgical and obstetric history.
Medications: Current and record any allergies

B-Contributory factors:
Assess mobility, cognitive impairment, manual dexterity, skin integrity, Lifestyle, e.g smoking cessation, communication difficulties, environmental factors, e.g access to toilet facilities, social circumstances

C- Fluid intake see step 3

Toileting pattern

TIP: Bladder& bowel assessment form available at www.hse.ie/continencecare

Presenting continence problem

Allow client to describe symptoms in their own words. Where the person is unable to provide details due to a cognitive impairment or intellectual disability, the carer/professional caring for them may provide details of symptoms and history. Discuss symptoms and how it impacts their daily life.

STEP 2: Urinary assessment: the symptoms should identify the possible cause of bladder dysfunction. There may be more than one cause. If **clinically indicated** refer to Medical Practitioner.

STEP 3: Bowel assessment. Client, carer or RN completes bladder & bowel record chart for 72 hours. Use Bristol stool chart to record type of stool. **Refer to bowel assessment pathway.**

TIP: Bladder & bowel record chart and instructions available at www.hse.ie/continencecare

STEP 4: Instigate conservative management

Stress incontinence
- Treat constipation
- Treat chronic cough
- Reduce weight
- Fluid intake 1.5-2L daily unless medically contra-indicated
- HSCP referral for further assessment e.g physio, OT, dietitian
- Pelvic floor exercises

Urgency incontinence
- Fluid intake 1.5 - 2L daily unless medically contra-indicated
- Reduce caffeine intake & other stimulant drinks
- Bladder retraining
- Pelvic floor exercises
- Treat constipation
- Reduce weight
- Smoking cessation
- HSCP referral for further assessment e.g physio, OT, dietitian
- Medication review
- GP referral

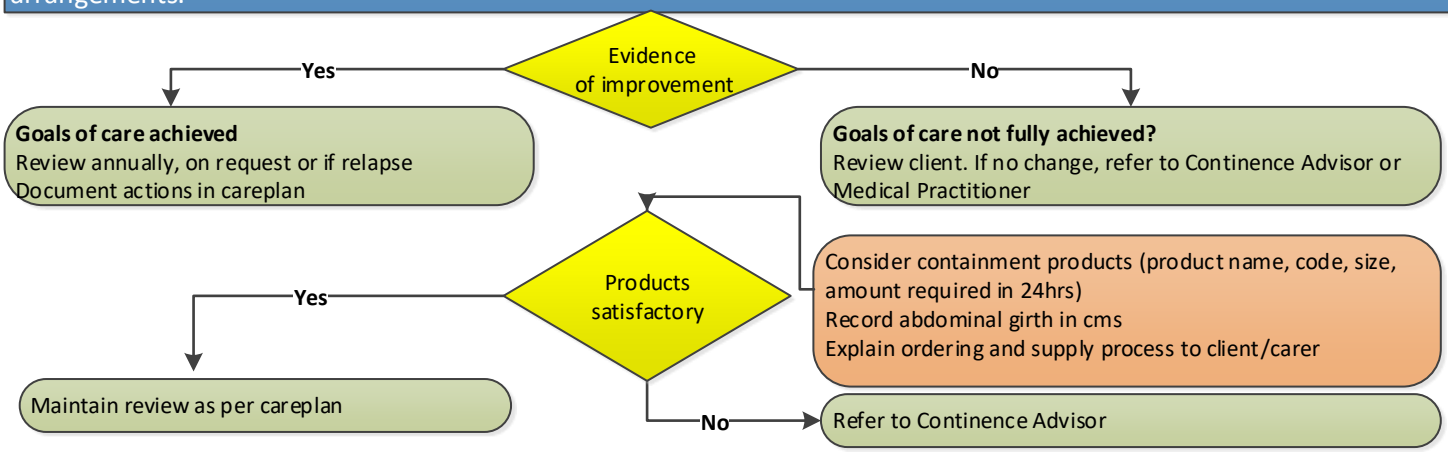
Mixed incontinence

As per treatment for stress incontinence and urgency

Functional incontinence
- Make toileting easier
- Improve access to toilet
- Provide toilet substitute
- Toilet prompting
- Timed voiding for clients with confusion
- Clothing adaptations

Overflow
- Reduce caffeine intake
- Fluid intake 1.5-2L daily unless medically contra-indicated
- Refer to GP/ Continence Advisor for further investigation & definitive diagnosis

STEP 5: Care plan devised by RN in consultation with client. If continence containment product required forward completed order form to relevant CHO data inputter/ continence advisor/CNS/ADPHN/ or as per local practice arrangements.



STEP 6: Repeat assessment must be carried out annually or earlier if there is a change in client's condition. The assessment should be completed face - to - face where possible.