Baseline (Level 1) assessment and management of bladder and bowel function

(Adapted from CHO8)

Part 1

Name: _____ Date of birth: _____ Gender: _____

Address: _____

Eircode: _____ Phone: _____ Mobile: _____

Contact person and relationship to client: _____ Mobile: _____

GP name: _____ Address: _____

Client consents to: **Data collection** Yes □ No □ **Nursing assessment** Yes □ No □

Sharing of information with other members of multi-disciplinary team Yes □ No □

GMS (medical card) number: _____ Long-term illness number: _____

Is the Fair Deal subvention availed of (for nursing home/unit)? Yes □ No □

Presenting continence problem			
When did it start?			
Treatment history			
Urinary catheter	Yes	No	
Incontinence occurs	During the day	At night	
Degree of incontinence	Light (damp)	Moderate (wet)	Heavy (change clothes)
Is the problem causing	Anxiety	Low mood	Restricting activities, social interactions
Information obtained from	Client □	Relative □	Carer □ GP □ Other □

Part 2		
Disability (if any)		
In residential care?	Yes	No
Relevant medical, surgical or obstetric history		
BMI		
Contributory factors (please comment):		
• Mobility impairment		
• Cognitive impairment		
• Communication impairment		
• Manual dexterity		
Daily fluids (type & amount)		
Toileting pattern	Independent	Needs assistance
Specific toileting accessibility problems (details)		
List current medication (dosage not required). List any bladder or bowel medication (include dosage), and other meds impacting on bladder bowel function, e.g. diuretics, anti-depressant E		
Allergies		

Part 3: For all clients who have attained toileting skills – urinary assessment (circle as relevant)		
		Possible cause

Do you leak when you: • laugh • sneeze • exercise • get up from a chair	Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □	Stress incontinence
Do you have an urgent need to use the toilet?	Yes □ No □	Overactive bladder, urge incontinence
Do you have difficulty delaying passing urine?		
Does urine sometimes leak before you reach the toilet?		
How frequently do you visit the toilet? Does the bladder wake you at night? Do you ever wake with the bed wet?	During the day ____ At night ____	Overactive bladder (>7 per day and >2 at night) Retention with overflow
Does your bladder still feel full after passing urine?	Yes □ No □	Retention with overflow or outflow Obstruction
Do you sometimes have difficulty passing urine, having t wait or strain?	Yes □ No □	
Do you have a weak urine flow?	Yes □ No □	
Do you have pain on passing urine?	Yes □ No □	
Do you have frequent urine infections?	Yes □ No □	

Urinalysis: _____ **Date:** _____

If urinalysis is abnormal refer client to G.P. Date referred: _____

Form completed by: _____ Title: _____ Date: _____

Client name: _____ D.O.B. _____

Part 4. Bowel assessment (please circle as relevant and give details where needed):		
How often do your bowels open?		
Do you experience: • Constipation • Diarrhoea	Yes Yes	No No

Do you have any faecal incontinence? Does this occur on the way to the toilet? Does this occur after a bowel motion Do you ever soil without knowing Can you control wind	Yes	No
Bristol stool scale – type of stool:		
Do you use laxatives?	Yes (list type and dose)	No
Has your bowel pattern changed?	Yes	No
Do you have difficulty controlling your bowe motion?	Yes	No
Have you noticed blood on your stools?	Yes	No
Do you experience any pain on defecation?	Yes	No
Stoma	Yes (include details)	No
Further information:		
Skin condition (groin, buttocks): healthy red excoriated other (specify)		
Please complete a bladder and bowel record chart for three days. **Date started: / /**		

Part 5: Summary of registered nurses assessment and comments:

_____

_____

_____

_____

Part 6: Give details of management and care plan:

Fluid review	Yes ☐ No ☐	Diet review	Yes ☐ No ☐
Toileting	Yes ☐ No ☐	Pelvic floor exercises	Yes ☐ No ☐

Is client confident doing exercises correctly and knows how to progress them? If not, refer to physiotherapist or Continence Advisor trained in PFMT.

Bladder retraining	Yes ☐ No ☐	Toileting aids required	Yes □ No □

Information leaflets given

Anatomy and physiology of continence and treatment options discussed? Yes ☐ No ☐

Care plan developed with client or relevant person: Yes ☐ No ☐

Care plan discussed and agreed with the client: Yes ☐ No ☐

Referral to GP for OAB/UI medication following 6 weeks bladder retraining if no improvement

Part 7: Give details of continence containment products (if required):

Provide details of product code and amount required _____

_____ Abdominal girth measurement _____ cms

Client informed of the system and processes for home delivery of continence products: Yes □ No □

Client informed of repeat assessment and re-ordering of products: Yes □ No □

Check client understands information given: Yes □ No □

Client requested further information on the process: Yes □ No □

Part 8:

Assessed by: _____ Title: _____ Date: _____

Address: _____

Part 9: Forward assessment to relevant continence advisor - Clients require a medical referral letter if they need to be seen by the continence advisor for further assessment.

Continence advisory service feedback:

Level 1 assessment received □ Date:_____

Bladder and bowel record chart completed Yes □ No □

Recommendations:

_____

_____

Products approved: Yes □ No □ Details: _____

Home delivery to start: Yes □ No □ Date of first home delivery: _____

Signed: _____ (Continence Advisor) Date: _____