DIRECTIONS FOR USE OF URINARY INCONTINENCE SCREENING TOOL AND STRATEGIES FOR INITIAL MANAGEMENT OF URINARY INCONTINENCE©

PURPOSE: To provide a tool for:

1. Recording individual's symptoms of Incontinence
2. Determining type of Incontinence
3. Guiding appropriate management of urinary Incontinence

USERS: Nurses/Health Care Professionals proving care to clients with identified urinary Incontinence.

INSTRUCTIONS:

- ➢ Addressograph or label form
- ➢ Date at top of sheet
- ➢ Record client's responses to questions
- ➢ If you do not check yes – no is assumed
- ➢ Record results of assessment procedures (eg urine culture, check for distention)
- ➢ Conclusion of Assessment: Review check marks to determine type(s) of Incontinence indicated. (May be more than one type)

***NOTE:** If client is cognitively impaired and cannot answer questions: then fill out the Urinary Incontinence Screening Tool and Strategies for Individuals with Cognitive Impairment form (CHA 0240).

DO NOT USE: If a client has been assessed in the past, do not use this form unless their management strategies are not working.

CHOOSE ONE OR BOTH OF THE FOLLOWING:

1. Assessor Management

- ➢ Proceed to Strategies for Initial Management of Urinary Incontinence form (CHA 0241)
- ➢ If client is complicated:
  1. Refer client as per referral pathway and
  2. Implement appropriate management strategies concurrently

2. Referral

- ➢ See Urinary Incontinence Referral Pathway (see reverse)

URINARY INCONTINENCE REFERRAL PATHWAY©

First Level	***Second Level***	***Third Level***

1. Identification of Urinary Incontinence (UI).
 	
2. Screening
• Implementation of UI Screening Tool
 	
3. Initial Management of UI
• Implementation of Initial Strategies
 	
4. Reassessment of UI
 	
5. Referral to 2nd Level
• As appropriate and also according to client choice.
	Family or attending physician
	
	Physiotherapy Clinic
	
	• Physiotherapists trained in pelvic floor disorders.
	• For further assessment of stress, urge or mixed incontinence.
	• Electrical stimulation and biofeedback.
	
	• For clients who have done pelvic muscle exercises or bladder training for 4 weeks without improvement (should be motivated, cognitively intact and able to attend clinic).
	• Give intensive follow-up.
	
	NACS/Clinical Nurse Specialist
	• Comprehensive nursing assessments for:
	  • Home bound individuals (NACS only)
	  • Complicated clients
	  • Clients non-responsive to initial strategies
	
	• Non-invasive diagnostic testing e.g. uroflow, post void residual by ultrasound
	• Counseling/teaching regarding products, catheterization, pelvic muscle exercises, and bladder retraining.
	
	Private Clinic – Nursing ***Note:*** For clients (females only) willing to pay fee for service and able to attend clinic.
	
	• For further assessment, reinforcement of strategies and biofeedback.
	• Gives intensive follow up.
	
	Referral to 3rd Level as appropriate
		Note: Physician referral is required
		
		Video Urodynamics
		
		• Comprehensive urological diagnostics (invasive testing)
		  • Pre-operative assessment
		  • Differential diagnosis of incontinence unresponsive to treatment
		  • Confirmation of urinary obstruction
		
		Specialist Referral
		
		• Urologist
		
		• Urogynecologist
		
		• Gynecologist

* AADL authorization of products can occur after adequate assessment and intervention at first or second level.
* Clients can access services at any point on pathway.

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URINARY INCONTINENCE SCREENING TOOL©

DATE: ______________

1. Have you ever been assessed for urinary incontinence? — Yes ☐
   When ___________ *Who* ____________________

2. Have you noticed a recent change in your incontinence? — Yes ☐

3. Do you have discomfort or burning when you pass urine? — Yes ☐ - UTI
   Date urine culture done: ______________
   Results: ______________________________ *Treated?* Yes ☐

4. Do you have difficulty getting to the toilet? — *At home* Yes ☐ *Out of the home* Yes ☐

   Why? Distance too great ☐ *Cannot see where to go (glasses, lighting)* ☐
   Cannot get out of chair or bed by yourself ☐ *Cannot uncover yourself in time* ☐
   Cannot sit down on the toilet or raise up from the toilet ☐

5. Are you constipated? — Yes ☐ May contribute to incontinence
   Intervention ______________________________
   Results ______________________________

6. When you feel the urge to go, do you have trouble getting to the bathroom in time? — Yes ☐ - Urge

7. Do you go to the bathroom more often than every 2 hours? — Yes ☐ - Urge

8. Do you ever leak large amounts or the entire contents of your bladder? — Yes ☐ - Urge

9. Do you wake up wet at night? — Yes ☐ - Urge

10. Do you have to get up more than 2 times at night to go to the bathroom? — Yes ☐ - Urge

11. Do you dribble on the way to the bathroom? — Yes ☐ - Urge

12. Do you dribble continuously? — Yes ☐ - Overflow
    Check for distended bladder: Date __________
    Results ______________________________

13. Do you have to strain to pass urine? — Yes ☐ Overflow or Impaired Bladder Contractility

14. Do you have the feeling that your bladder is not empty after passing urine? — Yes ☐ Overflow or Impaired Bladder Contractility

(over)

15. Do you have difficulty starting your stream of urine? Yes ☐ - Overflow or Possible Obstruction

16. Do you leak small amounts with activity (for example: lifting, coughing, sneezing)? Yes ☐ - Stress

17. Do you leak during the day only? Yes ☐ - Stress

# of pads presently used per day: _______ Brand names: ____________________
(include toilet paper pads, face cloths, etc.)

Client asked to complete Bladder Record for additional information Yes ☐ No ☐

Comments: ____

____

____

____

____

____

CONCLUSION OF ASSESSMENT

Type of incontinence likely in this patient (Could be more than one)

[ ] URGE [ ] STRESS [ ] OVERFLOW

Managed by Assessor [ ] - Proceed To Strategies For Initial Management

OR

Referral For Assessment And Management:
(Please indicate name of professional where possible)

☐ Family Physician ____________________ ☐ Urologist ____________________
☐ NACS ____________________ ☐ Urogynecologist ____________________
☐ Physical Therapist ____________________ ☐ Other ____________________

(Send copy of this tool and current medication list with referral)

Date ____________ **Signature of Assessor:** ____________________

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URINARY INCONTINENCE SCREENING TOOL AND STRATEGIES FOR INDIVIDUALS WITH COGNITIVE IMPAIRMENT ©

Date: ______________

Assessment

1. Attempt to use the Urinary Incontinence Screening Tool by interviewing client and/or caregiver. If they are unable to answer questions - complete questions 3, 4 and 5 only.

2. If a caregiver is available ask him/her to complete a 3 day bladder and bowel record.

3. Teach caregiver to use bladder and bowel record to observe for consistent behaviors prior to incontinence.

4. If it is not possible to complete a diary - attempt to get answers regarding types and amounts of fluid intake, bowel movements, number of incontinent episodes and voiding frequency and amount.

5. Inquire about number of hours spent in bed.

Strategies (Please check the boxes that apply)

1. Fluid Intake:

- Encourage fluid intake of 6 - 8 glasses per day. ☐
- Decrease caffeine intake to under 2 cups. ☐
- If night time incontinence is a problem, decrease evening fluid to a minimum. ☐

2. Bowel Routine

- Establish a regular bowel routine ☐

3. Toileting

- Based on bladder record, establish a toileting regime e.g. every 2 ½ - 3 hours or before meals and bedtime. ☐

  - ➢ When toileting, the client should not be rushed.
  - ➢ Use terminology that is familiar to the client "It's time to go to the toilet" or "Are you wet or dry?"
  - ➢ It may be necessary to actually place the client on the toilet.
  - ➢ Give positive reinforcement for dryness.
  - ➢ Timers are helpful for people who just "forget to go."

(over)

4. Environmental Adjustments

Environmental Adjustment
OT assessment for mobility, transferring and equipment needs ☐ Clothing Modification ☐
Commode ☐ Spillproof urinal ☐ Female urinal ☐ Freshette ☐ Raised toilet seat ☐
Toileting bars ☐ Toileting q3h ☐ Prompted voiding ☐ Nightlight ☐ Other ☐

Improve ability to find toilet by:

- Using signs or pictures on the bathroom door. ☐
- Using signs on floor for client who looks at floor as he/she walks. ☐
- Removing bathroom door if possible so client can see the toilet. ☐
- Put reflector tape around the door. ☐
- Place night lights near the bathroom and in the bathroom. ☐

5. Enhance Mobility

- Establish a routine of activity. ☐
- Establish a reasonable bedtime. ☐

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STRATEGIES FOR INITIAL MANAGEMENT OF URINARY INCONTINENCE©

Type of incontinence URGE ☐ STRESS ☐ OVERFLOW ☐
(as identified on Screening Tool)

Bladder Record Reviewed: ______ **Date:________________**

Check any of the management strategies you choose. Cross it out and date it if has been tried and did not work.

ENVIRONMENTAL ADJUSTMENT

OT assessment for mobility, transferring and equipment ☐ Clothing modification ☐
Commode ☐ Spillproof Urinal ☐ Female Urinal ☐ Freshette ☐ Raised toilet seat ☐
Toileting Bars ☐ Toileting q3h ☐ Prompted Voiding q3h ☐ Nightlight ☐ Other ☐

URGE	STRESS	OVERFLOW
☐ Fluids intake 6 - 8 cups/day ☐ Limit evening fluids ☐ Limit caffeine to less than 2 cups/day ☐ Limit alcohol ☐ Voiding/toileting q3h ☐ Recommend alteration of medication (eg diuretics, cholinergics) if feasible ☐ Urge Suppression ☐ Bladder retraining ☐ Product options	☐ Fluid intake 6 -8 cups/day ☐ Limit caffeine to less than 2 cups/day ☐ Limit alcohol ☐ Void q3h ☐ Pelvic muscle exercises ☐ Product options	☐ Fluid intake 6 -8 cups/day ☐ Limit evening fluids ☐ Double voiding ☐ Positional voiding ☐ Intermittent catheterization ☐ Recommend discontinuation of anticholinergics &/or tricyclics ☐ Product options ☐ Referral

REASSESSMENT DATE: ________________ (Do 2 - 4 weeks post-intervention)

DESCRIBE EFFECTIVENESS OF INTERVENTION: ____

____

____

____

Authorization for AADL supplies done? ☐Yes ☐No
If yes, specify: ____

____

(over)

CH-0241 Oct 1998

Referral for further assessment and management
(Please indicate name of professional where possible)

☐ Family Physician____________________ ☐ Urologist ____________________

☐ NACS ____________________ ☐ Urogynecologist ____________________

☐ Physical Therapist ____________________ ☐ Other ____________________

(Send copy of this tool and current medication list with referral)

Date of referral: ____________

Signature of Assessor: ____________________________

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BLADDER AND BOWEL RECORD

WHY IS IT IMPORTANT TO KEEP A RECORD?

A bladder and bowel record gives important information to the health care team, about incontinence, voiding and fluid intake patterns. This information is very important in planning treatment programs and in the ongoing evaluation of a person's treatment.

HOW DO I KEEP A BLADDER AND BOWEL RECORD?

Time — The time an event happens must always be recorded on the appropriate time line.

Amount/ type of drink — Each time fluid has been taken, write the amount (in cups or mls) and the type of fluid (e.g. coffee, juice or milk) in the second column.

Urination — Each time urine is passed in the toilet write the amount (in cups or mls) in the third column. If for some reason you are unable to measure the urine, please put a ✓mark at the time the urine was passed.

Amount of urine — Each time there is leakage of urine, write in the fourth column if it was a small or a large amount.

Activity — In the fifth column, write down the activity caused before the leakage of urine. Do this by picking a number from the list below the record marked "Behaviour Prior to Incontinence", that best describes the behaviour that you saw.

Bowel Movement — In the sixth and last column write the number of the type of bowel movement; pick the number from the list at the bottom of the record marked "Bowel Movement".

Number of pads — Beside number of pads used for 24 hours, write the number of pads used. If no pads were used but other things were used (i.e. paper towels or wash cloths) write that number.

Type of pads — After type of pads write whether menstrual or incontinence pads were used and what weight (i.e. pantyliner or maxi pad) or write down anything else that was used to soak up the urine.

NURSES/STAFF

If possible, record the post void residual.

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BLADDER AND BOWEL RECORD

Patient Name:

Date: **Record Day:**

Time	Amount and type of drink	Urination in toilet (✓ or amount)	Incontinence episode		Activity*	Bowel movement**
			Small	Large		
6 – 7 AM						
7 – 8 AM						
8 – 9 AM						
9 – 10 AM						
10 – 11 AM						
11 - 12 PM						
12 – 1 PM						
1 – 2 PM						
2 – 3 PM						
3 – 4 PM						
4 – 5 PM						
5 – 6 PM						
6 – 7 PM						
7 – 8 PM						
8 – 9 PM						
9 – 10 PM						
10 – 11 PM						
11- 12 AM						
12 – 1 AM						
1 – 6 AM						

***Activity prior to incontinence:**

1. Coughing or sneezing
2. Urgency
3. Pacing
4. Restless, fidgeting
5. Intense emotion
6. Repetitive verbalization
7. Agitation
8. Touching self/picking at clothing
9. Other (please specify)

****Bowel Movement:**

1. Diarrhea
2. Toothpaste like
3. Formed but soft
4. Formed and hard
5. Pebble like

Number of pads used per 24 hours: ____________________

Types of pads: ____________________

NURSES/STAFF:

Post void residual if possible: ____________________

(See reverse for instructions)

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BLADDER RECORD

WHY IS IT IMPORTANT TO KEEP A RECORD?

A bladder record gives important information to the health care team, about incontinence, voiding and fluid intake patterns. This information is very important in planning treatment programs and in the ongoing evaluation of a person's treatment.

HOW DO I KEEP MY BLADDER RECORD?

Time — The time an event happens must always be recorded on the appropriate time line.

Amount/ type of drink — Each time fluid has been taken, write the amount (in cups or mls) and the type of fluid (e.g. coffee, juice or milk) in the second column.

Urination — Each time urine is passed in the toilet write the amount (in cups or mls) in the third column. If for some reason you are unable to measure the urine, please put a ✓ mark at the time the urine was passed.

Amount of urine — Each time there is leakage of urine, write in the fourth column if it was a small or a large amount.

Activity — In the fifth column, write down the activity caused before the leakage of urine.

Number of pads — Beside number of pads used for 24 hours, write the number of pads used. If no pads were used but other things were used (i.e. paper towels or wash cloths) write that number.

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NURSES/STAFF

If possible, record the post void residual.

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MY BLADDER RECORD

DATE:_______________

PATIENT NAME:____________________ RECORD DAY: _________

Time Interval	Fluid Intake (amount)	Urinated in toilet (✓or amount)	Had an incontinent episode (✓)		Activity associated with leaking: eg. Sneezing, coughing "couldn't make it to the bathroom", "didn't know I had to go"
			Small	Large	
6 – 7 am					
7 – 8 am					
8 – 9 am					
9 – 10 am					
10 – 11 am					
11 – noon					
12 – 1 pm					
1 – 2 pm					
2 – 3 pm					
3 – 4 pm					
4 – 5 pm					
5 – 6 pm					
6 – 7 pm					
7 – 8 pm					
8 – 9 pm					
9 – 10 pm					
10 – 11 pm					
11 – midnight					
12 – 6 am					

Comments: ____________________________________
Number of pads used per 24 hours_______________________
Type of pads used: ________________________________

Nurses/Staff:
Post void residual if possible__________________________

(See reverse for instructions)