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			Initials / Designation	Date yyyy/mm/dd
▸ **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

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