

GUIDELINES FOR THE CONTINENCE ASSESSMENT FORM

The Assessment Form is designed to facilitate the collection of data required to identify the factors that contribute to the patient's incontinence and to formulate a treatment plan. The questions follow a logical format to guide you through the information gathering and to allow the patient to tell his/her story, if this is possible depending on the patient's cognitive status.

Section 1: Incontinence History

The first 3 questions address the onset of the problem of incontinence. Identifying whether or not it was a sudden or gradual problem; the length of time the incontinence has been occurring and whether or not it has remained the same or has worsened in the last 6 months.

Questions 4 through 6 identify the frequency of voiding both during the day, evening and at night, any associated incontinence which may be occurring, and whether or not a containment product is used. The information provided by the patient can be verified on the voiding record when they complete it as part of the assessment process. It is not unusual to find that the patient's initial estimate during the history taking is somewhat exaggerated when the actual voiding record is completed.

Questions 7 through 17 collect information related to specific symptoms of incontinence, such as stress loss of urine, urgency, urge loss of urine and overflow.

Questions 12 to 14 examine the patient's cognitive awareness of voiding and identify whether or not the messages sent to the brain when voiding are being received and interpreted by the patient. In patients where cognitive impairment is a problem, it is not uncommon to find that they are not aware of the urge to void or when they are incontinent. This is because their brain has lost the ability to interpret the voiding stimulus and therefore has also lost the ability to inhibit the urge to void.

Questions 15 to 17 focus specifically at symptoms related to the passing of urine. Hesitation with voiding may identify some type of outlet obstruction or inability to relax the external sphincter. Straining or manual expression of urine provides information about the tone of the bladder muscle and the patient's ability to relax this muscle when voiding. The strength of the urine stream may also be a symptom of a urethral outlet obstruction. Pain or dysuria with voiding may indicate an underlying urinary tract infection. Dribbling following voiding, or constant dribbling, provides information regarding the external sphincter's ability to completely close.

Questions 18 and 19 identify the patient's use of incontinence products, the type used, and the number on a daily basis.

Fluid intake:

In Question 20, information is gathered regarding the patient's fluid intake. You ask the patient to describe on an average day what they drink at various points during the day. You should insure that you ask the patient to clarify if their coffee, tea or pop is caffeinated or decaffeinated but be careful not to imply a judgement on the amount of caffeine that they are consuming. If you have asked the patient to provide their normal fluid intake accurately you should be able to answer the question 21 without specifically asking the patient that question. You will have enough information to identify if they are drinking caffeine, in which case you should be able to calculate the amount. Be sure you ask the patient about their alcohol intake (Question 22) if they do not voluntarily reveal this information. Both alcohol and caffeine act as diuretics on the kidneys and irritate the bladder and can be major contributing factors to problems of urgency and urge type incontinence.

Bowels:

Questions 23 to 25 deal specifically with bowel function. It is important to identify the patient's normal pattern of bowel movements and whether or not constipation is a factor. While patients may come with the problems of urinary incontinence, there may also be an underlying problem of faecal incontinence or constipation that they have not revealed. You should also identify any laxatives or medication they may be using.

Medical History:

Question 25 to 37 identifies common surgical procedures that the patient may have undergone, or common medical problems which the patient may have that would have a bearing on his/her problem of incontinence. While the patient may provide a very detailed medical history, these items have been identified as the most common issues that relate to incontinence and are meant to assist you in streamlining the process of gathering medical information.

Medication:

Questions 38 to 43 ask you to specifically identify from this list of medications any that may have an impact on bladder function.

Weight:

Question 44 records the patient's weight.

Functional Assessment:

Question 45 to 47 identify those issues related to function which may have an impact on the patient's ability to be continent. Access to the bathroom and toilet can also be factors that contribute to the incontinence problem. The patient's ability to ambulate and their general functional ability is information that is very important to assess in order to implement an appropriate and realistic plan of care.

¹Abilities Assessment:

Question 48 assesses four abilities:

- Self-Care Abilities
- Interactional Abilities
- Social Abilities
- Interpretive Abilities

Physical Assessment:

Prior to examination, it is important to have the patient attempt to void and measure the amount of urine voided (Question 49). The residual urine (Question 52) should be determined by bladder ultrasound or by an in-and-out catheterization. It is important to determine whether or not the patient is completely emptying their bladder and this residual urine is the method of doing that. The urine obtained should be sent for culture, or alternatively a urine dipstick may be used to determine if there are any bacteria present. If the dipstick is positive for white blood cells or nitrates (Question 50), the urine should be sent for culture (Question 53) to rule out infection (see urinalysis handout).

Finally, the condition of the perineum (Question 51) itself should be remarked upon in terms of recurring incontinence and prolonged use of product that may have caused a deterioration of this skin. You may need to make some recommendations regarding appropriate barrier creams.

Voiding Record (Question 54)

As part of the initial assessment, you may be asking the patient to complete a 4 or 5-day voiding record, which you will review during the first follow-up visit. You may wish to wait until you have received all the information before starting a program of treatment. However, this will be dependent on the patient's individual needs and you should make an individual assessment on this issue.

Contributing Factors:

Section 55 to 65: You should now review the assessment form and identify factors that you think are contributing to the problem of incontinence. These factors will help you identify the type of incontinence with which you are dealing.

Treatment:

Section 71 to 78: The list of contributing factors will help to identify the appropriate conservative treatment methods listed as Treatment Options on the form.

¹ Dawson, P., Kline, K., Crinklaw Wiancko, D., Wells, D. (1986). Nurses must learn to distinguish between excess and actual disability to prolong the patient's competence. Geriatric Nursing, Nov./Dec.

Wells D.L. and Dawson P. (2002). A Framework for Developing Nursing Knowledge About the Effects of Dementia on Older Persons' Abilities Journal of Applied Gerontology March 2002, vol. 21, no. 1, pp. 90-102(13).

The Voiding Record

A voiding record is a tool that allows the patient to record the amount he/she voids or is incontinent in a 4 day period. The voiding record provides a picture of the patient's incontinence and fluid intake.

Most people underestimate the severity of their problem and are surprised at the number of accidents that they actually have. The voiding record also helps to identify any relationship between fluid intake and voiding frequency or urine loss. Each voiding record is one day, which begins at 6:00 am and then proceeds in half hour intervals through the day.

The patient records the amount each time he/she voids and writes it down in the 'void' column next to the nearest half hour. The patient also documents their wetting episodes and fluid intake in the same manner. The staff may need to complete the voiding record.

At the end of the 4 days, you would have a detailed record of all toileting and wet events. This completed record, along with a complete assessment, will help you determine your diagnosis. It will also help you to recognize factors that contribute to urinary incontinence. For example, the amount of fluid intake- too much, too little, amount of caffeine the patient drinks and the relationship between these contributing factors and the incontinent episodes.

Urinalysis Strip Tests

Interpretation of Results for the NCA

Depending on the strip being used, the Bayer Reagent Strips provide tests for glucose, bilirubin, ketones, specific gravity, blood, pH, protein, urobilinogen, nitrite, and leucocytes in urine. Always handle specimens under sanitary conditions. Test within one hour, or if not possible, refrigerate and restore to room temperature before testing.

GLUCOSE: (visual reading time 30 seconds)

Glucose is a monosaccharide found naturally occurring in fruits. It is also formed from the digestion of carbohydrates and the conversion of glycogen by the liver and is the body's main source of cellular energy. Glucose is essential for brain and erythrocyte function. Excess glucose is stored as glycogen in the liver and muscle cells. Hormones influencing glucose metabolism include insulin, glucagon, thyroxine, somatostatin, cortisol and epinephrine. Normally, the kidneys reabsorb glucose, however it is normal for small amounts of glucose to spill into the urine. These amounts are usually below the test sensitivity, but may produce a result above negative on some occasions.

Normal finding: Negative

BILIRUBIN: (visual reading time 30 seconds)

The urinalysis strip tests screens for the presence of conjugated bilirubin in the urine. Bilirubin is a by-product of hemoglobin breakdown that is normally excreted by the gastrointestinal tract. When obstructive or hepatic jaundice occurs, conjugated bilirubin enters the bloodstream, rather than the gastrointestinal tract, and is filtered and excreted by the kidneys.

Normal finding-Negative

KETONE (ACETONE) BODIES: (visual reading time 40 seconds)

Ketone bodies are by-products of fat and fatty acid metabolism. For various reasons (such as diabetes mellitus, starvation, alcoholism) the body is unable to use glucose from glucose metabolism for energy. Therefore the body utilises fatty acids through fat metabolism for energy and ketones are found because they are the by-products of fat metabolism. Ketones present in the urine can help you to identify a possible problem with glucose metabolism. However, physiological stress conditions such as pregnancy, and frequent strenuous exercise may show positive for ketones.

Normal finding: Negative

BLOOD: (visual reading time 60 seconds)

The significance of the 'trace' reaction may vary among patients, and clinical judgement is required for assessment in an individual case. Development of green spots (intact erythrocytes) or green colour (free hemoglobin) on the reagent area within 60 seconds indicates the need for further investigation. Blood is often found in the urine of menstruating females. Elevated specific gravity may reduce the reactivity of the blood test. Captopril may also cause decreased reactivity.

Normal Finding: Negative

SPECIFIC GRAVITY: (visual reading time 60 seconds)

Specific gravity is the ratio of the mass of urine compared to the mass of an equal volume of water. Specific gravity is dependent on the ratio of urine solutes (chloride, creatinine, glucose, phosphates, protein, sodium, sulphates, urea, uric acid) dissolved in solvent. Specific gravity helps to evaluate the concentrating and filtration status of the kidneys, as well as the hydration status of the body. This test is helpful for the NCA to be able to predict if the patient is adequately drinking fluids. If the specific gravity is increased this could mean: Adrenal insufficiency, CHF, dehydration, diabetes mellitus, diarrhea, proteinuria.... If the specific gravity is decreased, this could mean: Chronic renal insufficiency, diabetes insipidus, hypothermia, increased ICP. Drugs that may cause a decrease in the specific gravity are: aminoglycosides, lithium, and methoxyflurane.

Normal Finding: 1.016-1.022

PROTEIN: (visual reading time 60 seconds)

Normally the urine is free of protein, or contains trace amounts of albumin and globulin, as the glomeruli prevent the passage of proteins from the plasma to the glomerular filtrate. Protein is the key indicator of renal pathology. Protein in the urine is established when a random sample is positive for more than a trace of protein. Normally, only low molecular weight proteins are small enough to pass through the glomerular membrane into the glomerular filtrate, and most of these are reabsorbed by the renal tubules. Proteinuria is a key indicator of renal pathology and can result from glomerular leakage, tubular impairment, breakdown of renal tissue, or from excess concentrations of low molecular weight proteins. Transient proteinuria may result from nonpathological states such as physical or emotional stress and body position.

Normal Finding: Negative

NITRITE: (visual reading time 60 seconds)

Humans normally oxidize ingested nitrite and excrete it as nitrate. The presence of nitrite in the urine indicates a urinary tract infection caused by organisms that reduce nitrate back to nitrite. A positive nitrite may mean: Cystitis, dysuria, pyelonephritis, and urinary tract infections.

Normal reading: Negative

LEUCOCYTES: (visual reading time 2 minutes)

Normal urine specimens generally yield negative results; positive results are clinically significant. Elevated glucose concentrations or high specific gravity may cause decreased test results. The presence of cephalixin, or high concentrations of oxalic acid may also cause decreased test results. Tetracycline may cause decreased reactivity and high levels of the drug may cause a false negative reaction. Nitrofurantion gives a brown colour to the urine that may mask the colour reaction on the reagent strip.

Normal reading: Negative