Guidance for completion of an adult urinary continence assessment

	Suggested question / discussion	Clinical rationale
1	**Presenting problem**: Ask the individual what problems you are experiencing with their bladder control?	To understanding the "bladder problem" for the individual's perspective. What terminology do they use? What is their level of understanding?
	How long have you had these problems? – few weeks/less than a year/ several years/lifelong. If they have had the problem for some time, have they had help before?	Is it a new problem or a long-standing problem?
	Why are you seeking help now?	Many individuals suffer in silence, accept it as normal, or are too embarrassed to ask for help. Has something significant just happened that has triggered them to seek help now?
	Can you think of anything that happened or changed in your life when your bladder problem started?	Looking for "clues" for the possible causes of the bladder problem: e.g. following childbirth, medication change, surgery, accident, sports
2	**Medical History** Ask the patient questions to gain an understanding of their medical conditions. Consider conditions that can affect bladder control:	Medical conditions can affect bladder control. Are other health professionals involved with their care?
	Diabetes – are they well controlled?	High blood sugar levels may be the cause of the bladder problem.
	Multiple Sclerosis	
	Stroke	
	Spinal injury/disease	Spinal injury – do they attend a Spinal Injury Unit.
	Parkinson's Disease	
	Dementia	
	Falls/ poor mobility	History of falls – have they been referred on to a Falls Prevention Service?
3	**Behaviour affecting continence** Ask questions to understand if there are any behaviour that affect their continence: Aggression Agitation Wandering	Behaviour problems may alter the structure of the assessment and continence treatment choices. Support from carers/family members and observations will be an

	None co-operative Unable to comprehend advice	important part of the assessment process.
4	**Female Surgical** Ask the female questions to identify if they have had any surgical procedures relating to their bladder:	
	Cystoscopy - if yes, why did they have it? What was the outcome?	If yes, they will probably have seen a Urologist/Gynaecologist. If cystoscopy is undertaken to investigate Haematuria, 2 week wait if bladder cancer is suspected.
	Urethral Dilation	This procedure undertaken to investigate a voiding problem or repeated urinary tract infections and to treat a stricture.
	Hysterectomy – if yes were the ovaries removed? and if yes, have they or are they on oestrogen replacement therapy?	Low oestrogen levels have a direct effect on the urethra, and when levels drop this affects the urethral closure, and could result in stress incontinence. Oestrogen is important for keeping the ligaments supporting the bladder bowel and womb strong and elastic. If oestrogen levels are low the ligaments become thinner, weaker and less resilient, this increases the chance of developing a prolapse / stress incontinence/passive faecal incontinence.
	Was it a vaginal or abdominal hysterectomy? Why did they have a hysterectomy?	Abdominal muscles will have been cut and there will have scar tissue. If the reason was fibroids or prolapse this could have stretch or weakened the pelvic floor muscles.
	Pelvic Floor Repair, if yes, when? Did it help their symptoms?	If yes you need to understand what surgery they have had, the outcome and what has happened since.
	Bladder Pressure Studies, if yes, when? What was the outcome?	If yes, they will have seen at Urologist/ Urogynaecologist.
5	**Male Surgical** Ask the male questions to identify if they have had any surgical procedures relating to their bladder:	

	Cystoscopy, if yes why did they have it? What was the outcome?	If yes, they will probably have seen a Urologist. If cystoscopy is undertaken to investigate Haematuria, 2 week wait if bladder cancer is suspected. Other reasons: voiding problems, bladder stones, stricture, pain in bladder, repeated urinary tract infections, enlarged prostate, urinary incontinence, abnormal cells in urine
	Was it a flexible or rigid cystoscopy?	Flexible cystoscopy is the most common and passes easily along the curves of the urethra. A rigid cystoscopy allows devices to be passed down the side channels to do procedures such as take biopsies, remove stones, remove polyps, insert stent (to help urine flow in a narrow section of the urethra), to obtain urine specimen from ureters (to check for infection or kidney tumour), to take x-ray of kidney/ureters.
	Urethral dilation	Undertaken to relieve urinary obstruction due to a stricture and improve urinary flow. The procedure stretches the scar tissue without damaging the lining of the urethra.
	Prostate surgery, if yes what type of surgery? When was it done? Where there any problems with bladder/bowel control post operatively? Treatment strategies, including pelvic floor exercises	Was the surgery for benign prostatic enlargement (BPH) or prostate cancer? The newer surgical techniques deliver a higher degree of surgical precision and therefore less complications of urinary incontinence.
	Bladder Pressure Studies, if yes when? What was the outcome?	If yes, they will have seen at Urologist.
6	**Menstrual Cycle/Menopause** Ask questions to understand about their menstrual cycle and if it affects their bladder control: Are they still menstruating? If yes, is it normal/irregular? Menorrhagia (heavy periods)? Are urinary symptoms worse before their period?	Low oestrogen levels often do not cause problems until 10 years after the menopause. Menorrhagia has many causes, referral on her investigation may be required, **referral on**. Hormone imbalance can affect bladder control.

	If not still menstruating, how old were they when they went through the menopause? Hot flushes? Vaginal dryness/ itchiness	The added pressure on the bladder by fibroids can cause urinary incontinence. Are there signs of atrophic vaginitis?
7	**Obstetric History** Ask questions to understand about their obstetric history: Number of pregnancies? Number of live births? Weights of babies? **Complications/ difficulties during labour?** Caesarean section, if yes was it planned or emergency? If emergency, how long were they trying to deliver vaginally before going for surgery? Episiotomy? 3rd/4th degree tear Forceps Long 2nd stage Short 2nd stage Breech Epidural	Pregnancy and labour are the main risk factors in developing stress urinary incontinence. Heavier weight babies put more pressure on the pelvic floor. These are risk factors increase the risk of symptoms of stress incontinence.
8	**Relevant Medications** Record all medications, prescribed and over the counter. Identify if they are taking drugs that could affect their bladder control, the main ones are: Diuretics Anticholinergics Hypnotics Sedatives Have any had any “medications changes”? if yes could this be related to their continence problem?	A significant number of drugs can affect bladder function. A significant number of medications have side effects that can affect bladder control.
9	**Known allergies**	Harm free care
10	**Impact on the quality of life of the individual/carer** Ask the individual how much their bladder problem is affecting their everyday life? Ask them to score it. e. g (1-not at all 2 3 4 5- a great deal)	Score at the time of assessment and repeat at the end of the treatment, to evaluated the effectiveness of the treatment from the individual’s perspective.

	Ask the carer how much the individual's bladder problem affects their everyday life? Ask them to score it.	Individuals with confusion or dementia, often deny or do not recognition they have a bladder problem and score low but if their carer is asked the same question they will score high.
11	**Urinary Symptoms** Ask questions to understand about their bladder problem: Is it painful to pass urine? (dysuria) Haematuria? (blood in urine) If yes send urine specimen and follow up result with medical practitioner. History of recurrent urinary tract infections, ask questions to try to identify the cause.	 Urinary tract infection is the most common cause but others causes including, sexually transmitted disease, lesion, trauma, vaginal dryness. If the dysuria is not related to infection, **referral on** may be indicated to identify the cause. Blood in urine needs investigated as it is a sign of bladder cancer. It can also be related to urinary tract infection, kidney stones and enlarged prostate in men. Need to identify the cause and give advice to reduce risk of further infections. Cause could be residual urine in bladder – check post void residual. Other causes: low oestrogen levels, glycosuria, kidney/bladder stones, sexual activity, having a catheter, abnormality of urinary tract. Referral on for further assessment may be indicated.
12	**Symptoms of an overactive bladder**: Do you pass urine more than 7 times in 24 hours? Is the desire to pass urine Urgent? How long can you hold for when you get the need to pass urine? - Less than 2 minutes - Up to 2 minutes - Up to 5 minutes - Longer than 5 minutes Is the desire to void always urgent?	 If yes, this is **Frequency.** If the desire is urgent and they cannot hold for 2 minutes this is **Urgency.** If urgency is a problem most individuals say they "cannot hold". For some the urgency occurs with movement or on standing, while sitting they feel ok.

	Do you wet before reaching the toilet? Triggers that can cause sudden bladder emptying: - Key in the door, leak as trying to open house door - Running water, leak when hear running water or put hands into water - Cold, leak when move from warm to cold environment or put hands into fridge/freezer	If yes, this is **Urge Incontinence** If yes to **Frequency** and **Urgency** this suggests a diagnosis of **Overactive Bladder (dry).** If yes to **Frequency, Urgency** and **Urge Incontinence**, this suggests a diagnosis of **Overactive Bladder (wet)**
14	**Nocturia** Are you woken from sleep with the urge to pass urine? If yes how often: - 1-2 times - 3-4 times - 5 + times	If yes, more than 2 times, this is **Nocturia.** Medical **referral** is indicated for severe symptoms or when conservative treatments are not effective or the problem is still bothersome.
15	**Nocturnal Polyuria** Do you feel you pass a greater amount of urine at night than during the daytime?	If yes, this suggests **Nocturnal Polyuria.** Analyse the Bladder dairy information to confirm the diagnosis. Is greater than 35% of the 24-hour urine production being produced during the night? **Referral on** is indicated if the problem is not resolved with simple healthy bladder advise.
16	**Nocturnal Enuresis** Do you wet the bed during sleep?	If yes, this suggests **Nocturnal Enuresis.** **Did you know -** 1% of the adult population are bedwetter? If nocturnal enuresis is not resolved with simple healthy bladder advise, medical **referral** to Urologist is recommended to identify the cause.

	If yes have you always been a wet the bed or is this a new problem? If it is longstanding problem have you had help previously? If yes tell me about it. If it is a new problem how long has it been happening for? Can you identify anything that happened in your life when it started?	If yes, this suggests **Primary Nocturnal Enuresis.** If yes, this suggests **Secondary Nocturnal Enuresis.**
17	**Symptoms of stress incontinence** Do you leak with exertion? Triggers: Cough, laugh, sneeze, lifting, exercise, sexual intercourse. Ask questions to gain an understand of the frequency and degree of leakage	 If yes, this suggests **Stress Incontinence**
18	**Symptoms of voiding difficulty – Outflow Obstruction or Hypotonic Bladder** Do you have hesitancy? Do you have to strain? How would you describe your flow? - Poor steam - Intermittent - Gush Do you dribble after you think you have finished? Are you wet all the time? Do you know when you leak? Position used to pass urine:	The symptoms of these 2 voiding difficulties are very similar but the causes are very different. **Referral** on for medical assessment is indicated to identify the cause which will determine the treatment. If yes, this is a symptom of a voiding difficulty - **Hesitancy** If yes, this is a symptom of a voiding difficulty - **Straining** A **poor or intermittent stream** is a symptom of a voiding difficulty If yes, this suggests a **Post Micturition Dribble**, this is a symptom of a voiding difficulty If yes, this suggests **overflow incontinence** Often the individual is unaware they are leaking, it occurs on movement when the bladder pressure is greater than the urethral pressure. Men often start to sit to void, as it is difficulty to direct a weak

	- Sitting - Standing - Hovering Do you feel you empty your bladder completely?	intermittent slow into the toilet from standing. If women hover over the toilet instead of sitting down they may not empty their bladder completely. Some individuals feel they do not empty their bladder fully, others will feel that they do.
19	**Symptoms of reflex incontinence** Do you have a lack of bladder sensation? Does your bladder empty without warning?	This is probably related to a neurological condition. Yes, to both these questions suggests a reflex bladder, medical **referral** is indicated to identify the cause which will determine the treatment.
20	**Functional Incontinence** Do you use the toilet independently in the day? Do you use the toilet independently at night? Do you use any equipment to aid toileting? - Urinal - Commode - Bedpan - Penile sheath - Urine director - Other Do you have any difficulty with? - Recognition of the toilet - Going to the toilet - Chair/toilet transfers - Bed transfers - Dressing and undressing - Standing tolerance - Sitting balance - Physical environment - Speed of mobility - Availability of carer	Where **Functional Incontinence** is a problem, observation of the individual's journey to and from the toilet and them using the toilet facilities (with their consent) is an important part of the assessment. The aim is to understand what difficulties the individual is experiencing get to and using the toilet, to enable a discussion about treatment options. **Referral** on to Occupational or Physiotherapy therapy services may be indicated.
21	**Fluid Intake** Number of drinks, cup/mug? Pattern of drinks over 24 hours Types of drinks	Compare the answers the individual gives to these questions to the information recorded on their 3 -day

		bladder diary. It is often a challenge to gain accurate information about fluid intake.
22	**Bowels**	Constipation or problems with defaecation may cause urinary incontinence, for example an impacted bowel could cause incomplete bladder emptying or chronic straining could cause stress incontinence. Or a bowel problem could be a consequence of the bladder problem, for example, reducing their fluid intake to try and cope with urgency and frequency could cause constipation. Faecal incontinence in association with urinary incontinence may indicate a more complex neurological problem.
	Ask questions to understand what is "normal" to the individual: - Normal bowel pattern/habit - Pattern of meals, usual foods – vegetables, fruit, cereals - Request them to indicate the types of stool they pass, using the Bristol Stool Chart and discuss - Ask if they are prone to constipation	The significant number of individuals who have a bladder problem, are constipated, if this is not identified and treatment for the bladder problem will not be as effective. For example, pelvic floor exercises will not be as effective if the individual is straining to open their bowels and a loaded rectum will press on the bladder and increase the urgency and frequency.
	Other questions to consider are: - Have you seen blood when you have opened your bowels? - Do you pass mucous from your bowels?	Blood in stool needs investigated as it is a sign of bowel cancer, referral on indicated. Significant amounts of mucous in stool needs investigated as it is a sign of a rectal ulcer, **referral** on indicated.
	- Faecal urgency? - Faecal leakage? - Are you aware of the need to have your bowels open? - Do you have any difficulty evacuating your bowels? - Do you experience pain?	If the answer to these questions is yes and the problem is not resolved with simple advice then a **Bowel Assessment** is indicated.

23	**Assessment of Quality of Life** Talk to the individual and /or use quality of life questionnaire. How do you feel about the bladder problems we have just discussed? Have you had to make changes in your life because of your bladder problems? What is the thing that most worries you about your bladder problems? Is there anything about your bladder problem that we have not talked about that is a concern to you?	An understanding of the impact the bladder problem has on the individual is essential when considering treatment options.
24	**Degree of leakage** Ask questions to understand the individual's perception how much they leak: - Dry - Slight - Moderate - Severe When does the leakage happen? Are aids or pads being used? If yes: - What? - How may over 24 hours? - Are they effective? - Source of supply? - Are they being worn /used correctly?	Compare these answers with the bladder diary information and pad weights, if completed. Individual perceptions will differ, for some a small patch on pants will be "slight" and for others "severe".
25	**Urinalysis** Perform urinalysis on a fresh catch specimen, the first void of the day is may be preferred as it is more concentrated but the time for routine testing is not important. The test should include: - Observation of colour, clarity and smell	Urinalysis is a clinical screening test which can identify medical disease that have gone unnoticed as they do not produce striking signs and symptoms. Examples include Diabetes Insipidus, glomerulonephritis, and chronic urinary tract infections.

	- Leucocytes	The presence of **leucocytes** indicates, **pyuria**, a condition where the urine contains white blood cells or pus and is a sign of bacterial urinary tract infection.
	- Nitrites	The presence of **nitrites** indicates the presence of coliform bacteria. The presence of protein indicates renal infection or diseases.
	- Protein	The presence of **protein** in urine is known as **proteinuria.** Proteins are large molecules and do not filter through the glomerulus into the urine. Presence indicates renal infection or diseases that have a secondary affect in the kidneys, hypertension, diabetes mellitus, hypothyroidism.
	- pH	Urine **pH** is used to classify if urine or acidic or alkaline. Urine is normally acidic with a pH of 5 or 6, 7 is neutral and above 7, is alkaline. A highly acidic urine output occurs with: dehydration, starvation, diarrhoea, uncontrolled diabetes and respiratory conditions. A highly alkaline urine occurs with: Urinary tract obstruction due to Kidney stones, chronic renal failure and respiratory conditions. Urine is usually more acidic in the morning (reduced breathing in sleep causes respiratory acidosis). A diet rich in vegetables and citrus fruit raises the pH producing an alkaline urine, vegetarians likely to have alkaline urine. A diet high in animal proteins, meat, milk and cheese, will keep urine acidic. Bacteria causing urinary tract infection or bacterial contamination will produce alkaline urine.
	- Blood	**Blood** in urine, **haematuria**, can be caused by urinary tract-specific problem, trauma, stone, infection, malignancy. Painless haematuria may

	-	be a sign of urinary tract malignancy warrants cytological investigation.
	- Specific Gravity	Specific Gravity (SG) measures the concentration of the urine. A SG under 1.010 the indicates hydration. A SG above 1.020 indicates dehydration.
	- Ketones	The presence of **ketones** bodies in urine, **ketonuria**, occurs with carbohydrate starvation, high protein diets and type 1 diabetes mellitus. The production of ketones is the normal response to a shortage of glucose, the ketones come from the breakdown of fatty acids to provide energy. Acetone is also produced as the fats burn to provide energy, which gives the fruity-sweet smell to the urine.
	- Glucose	It is not normal to find **glucose** in the urine. Although glucose is filters into the glomerulus it is normal absorbed from the renal tubules back into the blood. Presence of glucose in the urine is **glycosuria** and it is nearly always caused by elevated blood glucose levels. Diabetes mellitus is often diagnosed by urine testing.
	Study the information leaflet supplied with the urinalysis strips, the method of use, how to read, record and interpret the results.	
26	**Post void bladder scan** Post void bladder scan – undertake on first contact with all individuals (with consent).	The aim of the post void bladder scan is to identify if the individual is emptying their bladder effectively when voiding or if the residual left is significant. A post void bladder scan is an essential part of all continence assessment. (Frailty, age or dementia are not reason for not performing a bladder scan.) If a bladder scanner is not available intermittent catheterisation (aseptic non-touch technique) can be undertaken. Some individual can present with a normal voiding pattern but have a significant post void residual.

		A bladder scan needs to be completed at the first contact to enable prompt referral on if a high bladder capacity / residual volume is identified. A delay could result in the individual suffering long term bladder damage with the need for long term catheter management and the potential associated complications.
	If residual urine is found in the bladder discuss this with the individual, request them to try to void again and rescan.	
	If the post void residual is between 100-200mls give advice to promote more effective bladder emptying – sit down with feet well supported, take time, lean forward, double voiding. Arrange to repeat scan in 1-2 weeks.	The bladder will function more effective if the correct toilet posture and technique is followed.
	If post void residual is over 200mls discuss the scan results and the individual's bladder diary information with medical/specialist practitioner. Urgent discussion is required for high post void residuals 500- 1000+ mls.	A post void residual of 250mls is more significant if the voided volumes are low, 80-100mls than if they are higher 200-250mls. If the bladder stretches to hold volumes over 1000mls the detrusor muscle is very likely to become permanently damage, resulting an atonic bladder. The 1000mls is the volume voided + the residual volume. i.e. if voiding 400mls and have a post void residual of 740mls, the bladder is holding 1140mls.
	If individual is unable to empty their bladder try to identify when they last voided and what they have had to drink, estimate how much urine they think they will have in their bladder and then undertake the bladder scan. If a repeat scan is indicated, talk to the individual and carers and try to arrange to scan when you think they may have voided.	Some individuals are unable to void to request, this may be related to a neurological problem or dementia. Some individuals with Dementia can hold for significant periods of time, they may only void 1-2 times daily and pass large volumes.
28	**Analysis of 3-day bladder diary** A 3-day bladder diary is an essential part of a continence assessment, it is best if it is completed prior to the assessment to enable the information to be analysed in conjunction with the rest of the assessment. The information should be used to help the diagnosis.	The 3-day bladder dairy is a tool to support the diagnosis and can be repeated during treatment to enable evaluation. Measurement of the voids are important, if there is a tick

	- Record each day the time you get up and the time you go to bed - measurements each void in mls recorded on the chart to nearest hour (some individuals may void more than once per hour) - Record of degree of urgency for each void (0= no urgency, 1, 2, 3= very urgent) - Record of all wet episodes and degree of wetness. The degree of wetness could be subjective (dry, damp/dribble, wet/stream, soaked/flood) or by pad weighing. 24-hour Pad weights is a method to obtain this information it can be undertaken in Care Homes or Hospital Wards and individual's homes. - What you were doing when you leak – you may want some individuals to record this information - Record of pad/underwear changes The information required about fluid intake: - volume of drink (measure how much the drinking mug/cup/glass holds) - type of drink - time taken to nearest hour	only on the chart how do you know if 50mls or 500mls was voided. Support from relatives and carers we be needed to collect this information for some individuals. If it is not possible to measurement during the night, if a commode can be used and the total volume voided measured this will enable clinical judgements to be made. Urgency score is important when the diagnosis is overactive bladder. The chart can be repeated during treatment and the scores compared as part of the evaluation. Pad weighing can be undertaken as 1 gram is equivalent to 1ml. Voided volume (mls)= weight of wet pad (grams) – weight of day pad (grams).
29	**Female examination – see notes in principles of assessment word doc** **Female Perineum** examination: - visual skin assessment - visual examination of vulva with labia parted - visual assessment of a pelvic floor contraction - visual assessment when coughing to observe for stress leakage - vaginal examination to assess pelvic floor tone	Examination is an important part of the assessment. All assessors should have the skill and be competent to do a visual examination, conditions, such a prolapse, skin excoriation, could be missed if an examination is not undertaken.
30	**Male examination – see notes in principles of assessment word doc** Male perineum examination: - visual skin assessment - visual assessment of penis and scrotum - visual assessment of pelvic floor contraction - digital rectal examination to assess pelvic floor contraction	Examination is an important part of the assessment. All assessors should the skill and be competent to do a visual examination, conditions such a retracted penis, inguinal hernia, could be missed if examination not undertaken.
31	**Digital rectal examination – see notes in principles of assessment word doc** Digital rectal examination to identify	

	- identify if there is stool in the rectum and if yes, the type of stool present, is the individual constipated? - to assess anal tone	The incidence of constipation is high with all diagnosis of urinary incontinence. Reduced fluid intake and weak pelvic floor muscles are contributory factors
32	**Continence Diagnosis for urinary problem:** **At the end of the assessment the assessor needs analyse all the information and make a diagnosis:** - **Stress incontinence** - **Overactive bladder** - **Mixed incontinence** - **Incomplete bladder emptying** - **Reflex incontinence** - **Nocturia** - **Nocturnal polyuria** - **Nocturnal enuresis** - **Functional/Cognitive incontinence** - **Urinary tract infection** - **Unclear bladder diagnosis** - **Constipation** - **Faecal Incontinence**	For some individuals they will have a single diagnosis, for example, stress incontinence but for many there will be several causes, for example, an overactive bladder, nocturia, stress incontinence and constipation, this will therefore need 4 treatment plans. Discussion with medical practitioner is indicated for: - Incomplete bladder emptying - Reflex incontinence - Nocturia - Nocturnal polyuria - Nocturnal enuresis - Incomplete bladder emptying - Repeated urinary tract infections - Unclear bladder diagnosis