### Urinary dysfunction assessment tool (inpatient)

**Nursing**

#### Urinalysis

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Nursing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormalities: ________________________________</td>
<td>Urinary tract infection</td>
</tr>
<tr>
<td></td>
<td>Treatment: ________________________________</td>
</tr>
</tbody>
</table>

Sent for culture? □ Yes □ No  Date: __________

**Consider repeating MSU following treatment.**

#### Post void bladder scans

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Nursing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Pre void volume (mls)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More than 150mls post void, inform medical staff and repeat bladder scan.

Outcome/management: ________________

#### Information from 3 day frequency volume chart

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Nursing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day</td>
<td>1</td>
</tr>
<tr>
<td>Total intake (mls)</td>
<td></td>
</tr>
<tr>
<td>Total output (mls)</td>
<td></td>
</tr>
<tr>
<td>Number of voids in 24 hours</td>
<td></td>
</tr>
<tr>
<td>Number of wet episodes in 24 hours</td>
<td></td>
</tr>
<tr>
<td>Number of nocturia episodes</td>
<td></td>
</tr>
</tbody>
</table>

Problems/patterns identified from chart: ________________

Chart not completed. State why? ________________

- Review types and amount of fluid taken. Intake should be 1½ to 2 litres daily unless contraindicated. Inform medical staff if intake too low or too high.
- Consider bladder irritants contributing to symptoms for example tea, coffee, fizzy drinks and advice reduction if required.
- Look for patterns of frequency and possible causes for example following diuretics, linked to fluid intake.
- Look for predictable patterns of voiding/incontinence to aid retraining/toileting programme.
- If nocturia is more than twice per night and troubling patient – commence **nocturia care plan**.
### Patient Information

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Nursing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to admission were you incontinent of:</td>
<td>• Aim to provide the same product for use in ward and assess suitability for current needs.</td>
</tr>
<tr>
<td>□ Urine □ Faeces</td>
<td>• Ask family/carer to bring in a week’s supply of products from home.</td>
</tr>
<tr>
<td>□ Both □ No incontinence</td>
<td>• Always ensure correct fitting of pads with correct size of fixation pants or patients own close fitting underwear (see fitting guidelines).</td>
</tr>
<tr>
<td>How was this managed prior to admission?</td>
<td>• Continue with regular toileting.</td>
</tr>
<tr>
<td>□ Pads □ Washable pants</td>
<td>• Change pads when two thirds full unless faecal smearing.</td>
</tr>
<tr>
<td>□ Bed pads □ Urinal</td>
<td>• Ensure no oil based creams or talcum powders are being used which can block pads and affect absorbency.</td>
</tr>
<tr>
<td>□ Catheter □ Commode</td>
<td>In NHS Lothian, Cavilon cream (for red skin) and Cavilon spray (for broken/excoriated skin) should be used for incontinent patients.</td>
</tr>
<tr>
<td>□ Sheaths Type: ___________ Size: ______</td>
<td></td>
</tr>
<tr>
<td>□ Routine toileting Times: _______________</td>
<td></td>
</tr>
<tr>
<td>□ Regular prompting Frequency: ___________</td>
<td></td>
</tr>
<tr>
<td>If pads, what type?</td>
<td></td>
</tr>
<tr>
<td>Day: ______________________ How many? _____</td>
<td></td>
</tr>
<tr>
<td>Night: ____________________ How many? _____</td>
<td></td>
</tr>
<tr>
<td>Supplied by:</td>
<td></td>
</tr>
<tr>
<td>□ District Nurses</td>
<td></td>
</tr>
<tr>
<td>□ Buys own</td>
<td></td>
</tr>
<tr>
<td>Are they adequate for needs in hospital? ______</td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>If No, why: _______________________________</td>
<td></td>
</tr>
</tbody>
</table>

### How often do you leak urine?

| □ Never □ Occasionally | • It is never normal to leak urine so full investigation required to categorise type and commence treatment. |
| □ Weekly □ More than once per week | |
| □ Daily □ More than once per day | • Use this information to aid choice and suitability of containment product required while further investigations and treatment are ongoing. |

### How wet can you be if not wearing a pad?

| □ Light – wets underwear | |
| □ Moderate – wets outer garments | |
| □ Heavy – runs down legs | |
| □ Wet all the time | • Acceptance/participation of treatment/management plan can be dependent on patient’s perception of problem. |

| Overall, how much does leaking urine interfere with everyday life? | |
| 0 1 2 3 4 5 6 7 8 9 10 | |
| Not at all | A great deal |

Bladder and Bowel Nursing Team

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June 2016
## Information from 7 day bowel chart

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Nursing Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel last opened: __________________________</td>
<td>- Consider that faecal incontinence/smearing can be a sign of constipation.</td>
</tr>
<tr>
<td>Type: __________________ Amount: __________________</td>
<td>- Constipation can cause urinary symptoms such as urgency and incontinence.</td>
</tr>
<tr>
<td>Usual stool type: 1 2 3 4 5 6 7</td>
<td>- Inform doctor if signs of constipation.</td>
</tr>
<tr>
<td>Evacuation frequency: __________ per day/week</td>
<td>- Ensure adequate fluid intake/diet with adequate fibre content.</td>
</tr>
<tr>
<td>Faecal incontinence: ☐ Yes ☐ No</td>
<td>- Encourage regular mobilising.</td>
</tr>
<tr>
<td>If Yes, how often? ________________ per day/week</td>
<td>- Encourage to sit on the toilet at regular times for example after breakfast.</td>
</tr>
<tr>
<td>☐ Pain ☐ Straining ☐ Blood in stool</td>
<td>- Advise on correct evacuating position on toilet and assist if required.</td>
</tr>
<tr>
<td>Action taken: __________________________________</td>
<td>- Ensure laxatives administered are appropriate for stool type.</td>
</tr>
<tr>
<td>__________________________________</td>
<td>- Check for red flag symptoms and if any are present, inform medical staff (refer to Adult Bowel Dysfunction Protocol).</td>
</tr>
<tr>
<td>__________________________________</td>
<td>- Full bowel assessment may be required as per Adult Bowel Dysfunction Protocol.</td>
</tr>
</tbody>
</table>

## Symptom profile

### Stress incontinence

1. Do you leak urine when you laugh, cough, sneeze or lift? __________________________ ☐ Yes ☐ No
2. Do you leak without feeling the need to empty your bladder? __________________________ ☐ Yes ☐ No
3. Are you aware of leakage occurring? ____________________________________________ ☐ Yes ☐ No

Mainly Yes answers indicate stress incontinence.
Commence stress incontinence care plan.

### Urgency/urge incontinence (overactive bladder) with/without incontinence

1. Do you feel a strong sudden urge and have to go to the toilet immediately? ........ ☐ Yes ☐ No
2. Do you feel the urge to pass urine frequently? ............................................. ☐ Yes ☐ No
3. Are you woken up more than twice during the night to pass urine? ....................... ☐ Yes ☐ No
4. Do you sometimes pass urine in your sleep? .................................................. ☐ Yes ☐ No

Mainly Yes answers indicate urge incontinence/overactive bladder.
Commence urgency/urge incontinence (overactive bladder) care plan.

Answers across both suggest mixed urge and stress incontinence.
Commence care plan for most dominant symptoms.
Incomplete bladder emptying/overflow incontinence

1. Do you find it difficult to start to pass urine? ........................................ No
2. Do you have to push or strain to pass urine? ........................................ No
3. Does your flow stop/start several times? ........................................ No
4. Do you feel as though your bladder is not completely empty after passing urine? ........ No
5. Do you leak urine into your underwear just after passing urine? ........ No

Mainly Yes answers indicate incomplete emptying/overflow incontinence.

Commence incomplete bladder emptying/overflow incontinence care plan.

Functional incontinence

1. Do you know when to go to the toilet? ........................................ No
2. Can you identify the correct place in which to pass urine and faeces? ........ No
3. Can you walk to the toilet by yourself? ........................................ No

   Assistance required:
   - Supervision
   - Assistance of one
   - Assistance of two
   - N/A unable to use toilet

   Aids required: ____________________________________________________________
   Hoist: ________________________________________________________________

4. Can you undress and dress yourself before and after toileting? ........ No

   Assistance required:
   - Supervision
   - Assistance of one
   - Assistance of two
   - N/A unable to use toilet

   Aids required: __________________________________________________________

5. Can you get on and off the toilet independently? .................... No

   Assistance required:
   - Supervision
   - Assistance of one
   - Assistance of two
   - N/A unable to use toilet

   Aids required: __________________________________________________________

Mainly Sometimes or No answers, commence functional incontinence care plan.

Print name: ........................................................................................................
Signature: ........................................................................................................ Date: ........
### Medical

**Type of urinary dysfunction identified from nursing assessment**

**Medical conditions which may affect continence** (tick all that apply)

- [ ] Diabetes
- [ ] Multiple sclerosis
- [ ] Parkinson’s disease
- [ ] Dementia
- [ ] Stroke
- [ ] Spinal problems
- [ ] Neurological disorders
- [ ] Cardiovascular
- [ ] Obesity
- [ ] Mental health issues
- [ ] Learning disability
- [ ] Other

**Surgical history** (tick all that apply)

- [ ] Cystoscopy
- [ ] Bladder surgery
- [ ] Pelvic floor repair
- [ ] TURP
- [ ] Hysterectomy
- [ ] Bowel surgery
- [ ] Other

**Obstetric history**

- Parity: 
- Difficult delivery: [ ] Yes [ ] No
- Type of delivery: 
- Heaviest baby weight: 

**Review medications**

- On medications which can affect bladder function: [ ] Yes [ ] No
- List of medications:

- Changes made:

- PSA: 
- U&Es: 

**Physical examination** (tick all that apply)

- Date: 
- Full explanation given: [ ] Yes [ ] No
- Consent gained: [ ] Yes [ ] No
- Chaperone present: [ ] Yes [ ] No
- Name:

- Abdominal examination
  - Bladder palpable
  - Bowel loaded
- Comments:

- Skin condition
  - Generally healthy
  - Excoriated
  - Red
  - Broken
- Comments:

- Leakage on coughing
- Evidence of prolapse
- Atrophic vaginitis
- Comments/action taken:

**Digital rectal examination** (tick all that apply)

- Faeces in rectum
- Soft faeces
- Firm faeces
- Hard faeces
- Faecal impaction
- Bleeding
- Haemorrhoids
- Rectocele
- Prostate: Size: 
- Surface: 
- Comments:

Consider onward referral as per Lothian RefHelp Guidelines.
Patient's name: ............................................................... Date of birth/CHI: .................................

Medical action plan

________________________________________________________________________
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Print name: ........................................................................................................

Signature: ......................................................................................................... Date:  ..............