

We are happy to share this work with other health services but please acknowledge by including on your form – “Developed by Hunter Stroke Service, Hunter New England Local Health District”

Facility: _____

STRUCTURED URINARY CONTINENCE ASSESSMENT & MANAGEMENT PLAN

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

D.O.B. ____ / ____ / ____

M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Urinary Retention Screening and Management Guide

• Urinary retention may be quite painless. It is therefore important to actively evaluate the bladder from the outset, rather than passively await symptoms or problems.

• Measure Post Void Residual Volume (PVRV)

○ For 72 hours for newly admitted patients to evaluate the bladder and screen for retention (refer clinical guideline)

○ Whenever urinary retention is suspected, or reassessment required.

• TDS PVRVs may be unnecessary for patients with normal cognition and mobility, and no evidence of increased PVRV. A single scan would suffice.

• A normal PVRV is considered to be less than 100 mL

How to assess PVRV using a bladder ultrasound scanner.

1. Patient indicates need to empty bladder OR encourage patient to void

2. Ensure patient privacy and optimise voiding conditions: e.g., for many men the upright posture (including sitting over the toilet) is better than attempting to void while supine

3. Measure and record volume voided or ‘unable to void’ on fluid balance chart/continence management chart (page 3)

4. Place patient in supine position

5. Attend PVRV immediately (not more than 15 minutes) after patient void, using bladder ultrasound scanner

6. Take 3 volume measurements to ensure accuracy.

7. Use the following table to guide and support clinical judgement

PVRV result:

Action

Follow-up

> 400 mL

Urgent intermittent catheterisation

For patients considered to have an over distended bladder, consider resting the bladder for several days using IDC, then commence “Trial of Void ” or intermittent catheterisations

200 to 400 mL

Intermittent catheterisation

Reassess PVRV in 4 hours

100 to 200 mL

Monitor

Reassess PVRV in 4 hours

< 100 mL

Reassess within 24 hours

No treatment required if PVRV remains < 100 mL

Other points to consider

• Clinical judgement in conjunction with use of the urine retention guide is recommended

• Encourage double voiding to ensure optimal bladder emptying

• Maximum time between assessments should be: daytime = 4 hours and overnight = 8 hours

• Avoid indwelling catheter where possible

• If indwelling catheter is unavoidable, it should be removed as soon as it is no longer required, to reduce the risk of catheter associated complications. Review every 24 hours until removed.

• If intermittent catheterisation required – aim for a maximum of 5 catheterisations in 24 hours based on patient’s bladder capacity and PVRVs. Do not allow the patient’s bladder to fill (voided volume plus post void residual volume) beyond 450 mL during the day, or 600 mL during the night

• If PVRV remains above after 4 days refer to urologist or continence nurse

Refer to ACI Urology Network –Nursing: Trial of Void Hospital Guidelines 2008

Refer to ACI Urology Network – Nursing: Non Real Time Bladder Scanner 2008

* TDS = Three times per day

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Urinalysis

• Attended ☐ Yes ☐ No

• Abnormalities reported to medical officer ☐ Yes ☐ No ☐ N/A

• Culture if infection suspected e.g. urine positive for nitrites, leukocytes or blood, and symptoms of dysuria ☐ Yes ☐ No ☐ N/A

Post void residual volume (PVRV)

• PVRV bladder scan first 72 hours as a screen for urinary retention (refer clinical guideline).
☐ Yes after each void ☐ Yes random daily post void ☐ No ☐ N/A reason: _____
(refer to Urinary Retention Screening and Management Guide (page 4) if PVRV > 100 mL)

Is patient continent of urine?

☐ Yes→ end assessment here, monitor continence status, including PVRV as above
☐ No → continue continence assessment and complete management plan including PVRV for 72 hours (as above)

Urinary incontinence (UI) prior to admission

• History of UI ☐ Yes ☐ No

• Urinary incontinence type (if known) _____

• Duration ☐ < 6 months _____ Years ☐ Lifelong

• Incontinence pad use ☐ Daytime ☐ Night time ☐ Both ☐ N/A

Urinary catheter

• Urinary catheter: in situ ☐ Yes ☐ No ☐ urethral ☐ suprapubic

• Catheter intermittent: ☐ Yes ☐ No Frequency _____

• Reason for insertion: Retention ☐ Yes ☐ No Other _____

• Catheter inserted prior to admission ☐ Yes ☐ No Date _____

• Expected date of removal of catheter _____

Medical history

☐ Diabetes ☐ Previous stroke ☐ Back pain/injury ☐ Spinal cord injury
☐ Multiple Sclerosis ☐ Parkinson's Disease ☐ Cancer urinary tract ☐ Cystitis ☐ Obesity
☐ Chronic cough ☐ Urinary tract infection in last 12 months ☐ Enlarged prostate
☐ Chronic constipation Other _____

Surgical history

☐ Hysterectomy ☐ Bladder surgery ☐ Pelvic surgery ☐ Prostate surgery
Other _____

Medication review

• Request medical officer or pharmacist to review medications that may interfere with bladder or bowel function ☐ Yes ☐ No ☐ N/A

Hydration

• Ensure fluid intake = 2000 mL/day unless contraindicated. ☐ Yes ☐ No ☐ N/A

• If urine specific gravity ≥ 1030 the patient may be dehydrated. Increase fluids if not contraindicated. ☐ Yes ☐ No ☐ N/A

Renal function

• Refer to medical officer if history of renal disease ☐ Yes ☐ No ☐ N/A

Bowel assessment

• Bowel assessment form completed ☐ Yes ☐ No

• Does patient have faecal incontinence? ☐ Yes ☐ No ☐ Unsure

Abdominal assessment

• Palpable bladder ☐ Yes ☐ No ☐ Unsure

• Palpable abdominal mass ☐ Yes ☐ No ☐ Unsure

Perineal assessment

• ☐ Healthy ☐ Dry, thin mucosa ☐ Prolapse ☐ Vaginitis Other _____

• Refer to medical officer if abnormality detected ☐ Yes ☐ No

Cognition / communication

Poor cognition ☐ Yes ☐ No ☐ Unsure Dementia ☐ Yes ☐ No
Communication difficulties ☐ Yes ☐ No ☐ Unsure

Dexterity

• ☐ Independent ☐ Needs assistance

Current mobility

• ☐ Independent ☐ Walks with assistance ☐ Walks with aids ☐ Chair bound

• Falls Risk _____ Waterlow score _____

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Urinary Incontinence Types and Management Strategies

Identify patient signs and symptoms (column 1), define specific UI type document on page 3 (column 2)
Implement strategies specific to UI type (column 3). Indicate the strategies used document on page 3 (column 4) Y=yes N=no

Signs & Symptoms	UI Type	Management Recommendations and Strategies	Y/N
<ul style="list-style-type: none"> Unable to pass urine with bladder distension and pain or PVRV > 400 mL <p>Respond immediately <i>*may be painless after stroke</i></p>	<input type="checkbox"/> Acute Urinary Retention	Urgent PVRV bladder scan attended	
		If > 400 mL may require urgent catheterisation (see Urinary Retention Screening and Management page 4). Catheterisation attended	
		Medical Officer (MO) examined patient for mechanical obstruction	
		MO review of medications contributing to urinary symptoms	
		Assessed for / management plan for constipation	
		Fluid balance chart commenced	
<ul style="list-style-type: none"> Frequent small volume voids Hesitancy in starting urine stream Patient may be wet all the time Patient may feel that bladder not fully emptying 	<input type="checkbox"/> Chronic urinary retention <i>(Voiding symptoms associated with obstruction or underactive detrusor)</i>	PVRV attended if retention suspected.	
		Managed according to Urinary Retention Screening & Management Guide	
		Patient instructed on double voiding	
		MO examined patient for mechanical obstruction	
		MO review of medications contributing to urinary symptoms	
<ul style="list-style-type: none"> A sudden compelling desire to pass urine which is difficult to defer Involuntary leakage accompanied by or immediately preceded by urgency Inability to delay voiding once urge occurs can result in small or large volume losses. 	<input type="checkbox"/> Urgency urinary incontinence	Bladder retraining based on time and volume outcome (to increase bladder capacity, reduce frequency) commenced	
		Pelvic floor exercises	
		Instructed in delay techniques: mental distraction, perineal pressure, stop or sit, cross legs, raise toes	
		Appropriately sized continence pads provided	
		Advised to maintain adequate fluid intake, eliminate caffeine	
		MO review of medications contributing to urinary symptoms MO may consider Antimuscarinics	
<ul style="list-style-type: none"> Problems with mobility, upper limb function including dexterity, communication, vision, cognition, interpretation or unfamiliar environment. 	<input type="checkbox"/> Functional incontinence	Environment modified e.g. use of commodes, assistive devices	
		Whole multidisciplinary team focus on UI goals at case conference	
		Timed or prompted toilet schedule initiated using time and volume outcomes.	
		Continence aids provided where appropriate	
<ul style="list-style-type: none"> Complete bladder emptying often without warning or sensation OR Poor bladder emptying and retention. 	<input type="checkbox"/> Neurogenic urinary incontinence	Timed toileting schedule	
		MO may consider antimuscarinics	
		Provided with continence aids	
		If retention suspected, attend PVRV and refer to retention guide (p4)	
		Urology review and management attended	
<ul style="list-style-type: none"> Involuntary leakage on effort or exertion or on sneezing or coughing. Relatively small volumes. 	<input type="checkbox"/> Stress Incontinence	Physio consult for assessment & exercise recommendations	
		Pelvic floor exercises	
		Maintain hydration, prevent constipation, review medications	
		Continence aids provided where appropriate	
<ul style="list-style-type: none"> Sleep interrupted by need to void <p>Note: Nocturia is not a UI type but may exacerbate functional incontinence. Also a falls risk.</p>	<input type="checkbox"/> Nocturia Number of times / night	Educate patient to lay supine in the afternoon to encourage venous return and eliminate dependent oedema	
		Advised to restrict fluid intake at night e.g. give only sips after seven pm	
		Check medications	
<ul style="list-style-type: none"> Involuntary leakage associated with urge and also with effort, exertion, sneezing or coughing 	<input type="checkbox"/> Mixed incontinence	Managed according to UI types suspected as above e.g. stress and urge.	

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Management Plan

Urinary incontinence type/s _____

Referred to: ☐ Physio ☐ OT ☐ Speech ☐ Pharmacist ☐ Social Worker ☐ Continence Nurse ☐ MO

Specify _____

☐ Education and support provided to patient and carer ☐ Discussed in case conference

Use the preceding tables to help develop a UI management plan with the patient and/or carer incorporating patient preferences and goals.

Date _____ Print Name _____ Sign _____ Designation _____

Continence management chart

[illegible]