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

SCREENING for Urinary Incontinence (UI) and/or Lower Urinary Tract Symptoms (LUTS)		Date/ Initial
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 on admission as a screen for urinary retention (refer pg 4 for guide) • Yes after each void for 72hrs ☐ Yes random daily post void ☐ • N/A ☐ Reason: _____	
Prior UI &/or LUTS	• History of UI/ LUTS Yes ☐ No ☐ type (if known) _____ • If Yes: Duration < 6 months ☐ Years _____ • Incontinence pad use Day ☐ Night ☐ Both ☐ N/A ☐ Type_____	
Is patient continent of urine?	Yes ☐ → screen for LUTS, monitor continence status, including PVRV (as above) No ☐ → continue continence assessment, complete bladder diary and management plan	
Presence of LUTS and risk of UI	• None ☐ → monitor LUTS/ UI status, including PVRV (as above) • Urgency ☐ Overactive Bladder/ frequency ☐ Retention ☐ Nocturia ☐ • If present continue assessment, complete bladder diary and management plan • Patient at risk of UI? Yes ☐ - consider management plan to maintain continence No ☐ - **END ASSESSMENT HERE**	
Urinary catheter/ Urostomy	• Urinary catheter/Urostomy in situ: Yes ☐ No ☐ urethral ☐ suprapubic ☐ • Catheter intermittent: Yes ☐ No ☐ Frequency _____ • Reason for catheter insertion or intermittent catheterisation: _____ • Catheter inserted prior to admission Yes ☐ No ☐ Date _____ Complete continence management plan for care and/or Trial of Void – consider bladder retraining where appropriate	
ASSESSMENT for LUTS/ UI		
Relevant medical history	Diabetes ☐ Prior stroke ☐ Back pain/injury ☐ Spinal cord injury ☐ Chronic cough ☐ Neurological disorder ☐ Cancer urinary tract ☐ Obesity ☐ Cystitis ☐ Current UTI ☐ Enlarged prostate ☐ Chronic constipation ☐ Other ☐ _____ Urinary tract infection last 12 months Yes ☐ No ☐ If Yes: How many _____	
Relevant 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 ☐ Reason _____	
Hydration	Ensure fluid intake = 2000 mL/day unless contraindicated. Yes ☐ No ☐ N/A ☐ Urine specific gravity ≥ 1030 may indicate dehydration. Increase fluids unless contraindicated	
Renal function	Refer to medical officer if history of renal disease Yes ☐ No ☐ N/A ☐ NB: decreased Specific Gravity (<1010) on U/A and/or deranged urea and creatinine or low GFR on pathology may indicate renal failure.	
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 ☐ Pale Vagina (Atrophic Vaginitis) ☐ Fungal infection (white/ cream discharge) ☐ Incontinence associated Dermatitis ☐ Other_____ • Refer to medical officer if abnormality detected Yes ☐ No ☐	
Cognition / communication	• Cognitive Impairment: Yes ☐ No ☐ Unsure ☐ Dementia: Yes ☐ No ☐ • Delirium: Yes ☐ No ☐ Communication difficulties: Yes ☐ No ☐ Unsure ☐	
Dexterity	• Independent ☐ Needs assistance ☐	
Current mobility	• Independent ☐ Walks with assistance ☐ Walks with aids ☐ Chair bound ☐ Bed Bound ☐	

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'.

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HNE024825

Urinary Incontinence Type	Key Symptoms	Diagnosis (may be more than one)
Acute Urinary Retention	Unable to pass urine with bladder distension and pain or PVRV > 200 mL, can be very painful but may be painless in stroke	☐
Chronic Urinary Retention	Frequent small volume voids Hesitancy in starting urine stream Patient may be wet all the time – continually leaking Bladder may not completely empty May have large residual volumes with no discomfort	☐
Urgency Urinary Incontinence	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.	☐
Functional Urinary Incontinence	Problems with mobility and/ or upper limb function including dexterity. Problems with communication, vision, cognition, interpretation or unfamiliar environment.	☐
Neurogenic Urinary Incontinence	Complete bladder emptying often without warning or sensation Poor bladder emptying and retention	☐
Stress Urinary Incontinence	Involuntary leakage on effort or exertion or on sneezing or coughing. Relatively small volumes	☐
Mixed Urinary Incontinence	Involuntary leakage associated with urge and also with effort, exertion, sneezing or coughing	☐
Nocturnal Enuresis	Involuntary urination that occurs whilst sleeping	☐
Nocturia	Waking one or more times during the night to void	☐
Overactive Bladder	Frequent feeling of needing to urinate often voiding small amounts If associated with urine incontinence it becomes urgency urine incontinence	☐
Continuous Urinary Incontinence	Bladder continuously loses urine Bladder is unable to store urine	☐

Bladder Diary/ Continence management chart – determines normal voiding pattern and effectiveness of management plan

Date	Scheduled time	Actual time	Staff Initiated void	Patient initiated void	Volume voided	PVRV	Catheter volume	Incontinent (Y/N)	Initial
01/01/20	*e.g. 9am*	*e.g. 930am*	*Tick if staff prompt*	*Tick if pt. initiated*	*Measure output if needed*	*Bladder scan result*	*If needed*	*Episode of incontinence*	*initial*

Continue bladder diary/ continence management chart on continuation form HNEMR140B

BINDING MARGIN – DO NOT WRITE

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HNEMR140

HNE024825

BINDING MARGIN – DO NOT WRITE

Management Plan

Referred to: Physio ☐ OT ☐ Speech ☐ Pharmacist ☐ Social Worker ☐ Continence Nurse ☐ MO ☐ Specify_____
For all patients with UI, LUTS, retention or catheters on discharge refer to Community Continence Nurse for follow up ☐

Education and support provided to patient ☐ and carer ☐ N/A ☐

Use the preceding bladder diary to help develop a UI management plan with the patient and/or carer.

Management Strategies	**Date _____ Initial_____**	**Date _____ Initial_____**	**Date _____ Initial_____**	**Date _____ Initial_____**
Patient and/or Carer involved	Patient ☐ Carer ☐ N/A ☐	Patient ☐ Carer ☐ N/A ☐	Patient ☐ Carer ☐ N/A ☐	Patient ☐ Carer ☐ N/A ☐
PVRV bladder scans (document on bladder diary)	Frequency	Frequency	Frequency	Frequency
Monitor bowels (avoid constipation)	☐	☐	☐	☐
Catheter use Consider leg bag during the day for free drainage (ensure bladder sensation present)	Intermittent ☐ IDC ☐ SPC ☐ flip flow ☐ Frequency_____ Planned TOV_____	Intermittent ☐ IDC ☐ SPC ☐ flip flow ☐ Frequency_____ Planned TOV_____	Intermittent ☐ IDC ☐ SPC ☐ flip flow ☐ Frequency_____ Planned TOV_____	Intermittent ☐ IDC ☐ SPC ☐ flip flow ☐ Frequency_____ Planned TOV_____
Encourage double voiding	☐	☐	☐	☐
Timed toileting (Pt to monitor) Frequency =	Waking hrs Overnight	Waking hrs Overnight	Waking hrs Overnight	Waking hrs Overnight
Prompted voiding (N/S to monitor) Frequency =	Waking hrs Overnight	Waking hrs Overnight	Waking hrs Overnight	Waking hrs Overnight
Pelvic floor exercises	Yes ☐ No ☐ N/A ☐ Number/frequency	Yes ☐ No ☐ N/A ☐ Number/frequency	Yes ☐ No ☐ N/A ☐ Number/frequency	Yes ☐ No ☐ N/A ☐ Number/frequency
Delay techniques (e.g. distraction, perineal pressure, cross legs, raise toes)	Details	Details	Details	Details
Containment aids (e.g. wrap, pull up or slip pad, Penile sheath)	Type	Type	Type	Type
Adequate fluid intake	☐	☐	☐	☐
Limit caffeine	☐	☐	☐	☐
Afternoon rest with legs raised (nocturia)	☐	☐	☐	☐
Restrict fluid at night (e.g. sips after 7pm)	☐	☐	☐	☐
Modify environment (e.g. use of urinal, commode, proximity to bathroom, night light, call bell)	Details	Details	Details	Details
Medication R/V (consider antimuscarinics)	☐	☐	☐	☐
Other Management strategies used	Details	Details	Details	Details
Review continence management plan	Date due	Date due	Date due	Date due

STRUCTURED URINARY CONTINENCE ASSESSMENT & MANAGEMENT PLAN

WORKSHEET

HNEMR140 190122

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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)
  - TDS for 72 hours for newly admitted patients to evaluate the bladder and screen for retention
  - Note: TDS PVRVs may not be required if the patient has normal cognition and mobility and there is no evidence of increased PVRV. With these patients a single bladder scan can be attended.
  - PVRV should be attended whenever urinary retention is suspected, or reassessment required. .
- A PVRV of < 100mls may be considered to be normal depending on the patients bladder individual capacity and 24 hour urine output..

How to assess PVRV using a bladder ultrasound scanner.

1. Patient indicates need to empty bladder OR encourage patient to void. Note: if prompted toileting is used, the residual volumes may be higher
2. Ensure patient privacy and optimise voiding conditions: e.g. for many people 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 bladder diary and/or fluid balance chart
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. Encourage double voiding if PVRV greater than 200ml and repeat bladder scan

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 catheterisation
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 provided urine output is adequate

Other points to consider

- Clinical judgement in conjunction with individual patient assessment and the 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
- Commence PVRV scans on patient waking
- 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 500 mL during the day, or 600 mL during the night. This may require intermittent catheterisations to be attended.
- If PVRV not below 200 mL after 4 days refer to urologist or continence nurse
- Refer to Clinical Excellence Commission CAUTI prevention guidelines for catheterisation – http://cec.health.nsw.gov.au/keep-patients-safe/infection-prevention-and-control/cauti-prevention
- For patients who are unable to void consider IDC if urine volume >500ml as per Clinical Excellence Commission CAUTI prevention guidelines for catheterisation http://cec.health.nsw.gov.au/__data/assets/pdf_file/0007/288016/Pre-Insertion-Decision-Support-Tool.pdf
- Hunter New England Local Health District Urinary Catheterisation Guideline – HNELHD CG 17_12 http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0004/161248/HNELHD_CG_17_12_Urinary_Catheterisation_for_Adults_-_Acute_and_Community_Care_v2.pdf