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Identifying Continence OptioNs after Stroke

Continence Assessment

To be completed by Ward Nursing Staff

NHS
National Institute for
Health Research

uclan
University of Central Lancashire

HOW TO COMPLETE THIS QUESTIONNAIRE

If the patient cannot answer these questions, please try to gather the information from their carers or family.

It is important to ask all the questions. If the patient is unable to answer, please write the reason on the form.

SECTION 1
This section asks for details about the patient.

SECTION 2
This section is about clinical investigations. Please collect this information from the patient's case notes.

SECTIONS 3 and 4
These sections are about continence aids and the patient's cognitive status. Please collect this information from the patient's case notes and from the patient themselves.

SECTION 5
This section is about continence problems the patient had **before** their stroke. Please collect this information from the patient.

SECTION 6
This section is about continence problems the patient has **after** their stroke. Please collect this information from the patient.

Section 1: Details about the patient

Patient's name

____

Date of birth

D D M M Y Y Y Y

Patient's preferred language ☐ English Other →

Can the patient speak English? ☐ Yes ☐ No

Can the patient understand English? ☐ Yes ☐ No

Date of stroke onset

D D M M Y Y Y Y

Date of admission

D D M M Y Y Y Y

Date of this assessment

D D M M Y Y Y Y

Person completing this assessment

Print name **Signature**

Section 2: Clinical investigations

1 Female patients only:

(*Please tick one box for each question*)

Has the patient had a rectal examination?	☐ Yes	☐ No
Are they constipated?	☐ Yes	☐ No
Has the patient had a vaginal examination?	☐ Yes	☐ No

IF YES to any of the above, please record any results below:

e.g. vaginal prolapse, rectal prolapse, mass

2 Male patients only:

(*Please tick one box for each question*)

Has the patient had a rectal examination?	☐ Yes	☐ No
Are they constipated?	☐ Yes	☐ No
Was the prostate examined?	☐ Yes	☐ No

IF YES to any of the above, please record any results below:

e.g. enlarged prostate, rectal prolapse, mass

3 Has a dipstick urinalysis been performed?

(*Please tick one box*)

☐ Yes

☐ No

IF YES

What date was the most recent one performed?

Day Month Year

D	D		M	M		Y	Y	Y	Y

What were the results?

☐ Normal

☐ Abnormal → did it contain: ☐ Protein ☐ Blood

Other → ☐

4 Has an MSSU been performed?

(*Please tick one box*)

☐ Yes

☐ No

IF YES

What date was the most recent one performed?

Day Month Year

D	D		M	M		Y	Y	Y	Y

What were the results?

☐ Normal

☐ Abnormal → ☐ Colonisation ☐ Infection

5 Has a bladder scan been performed?

(*Please tick one box*)

☐ Yes

☐ No

IF YES

Please record date and residual volume below:

Date of most recent bladder scan **Residual volume**

D	D		M	M		Y	Y	Y	Y

6 Medications

Is the patient on any medications?
(*Please tick one box)*

☐ Yes

☐ No

IF YES
Please list below:

Medication	Does the medication impact on continence? (***please circle***)
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No

Section 3: Continence aids

Is the patient using any continence aids?

☐ No (***please go to SECTION 4***)

☐ Yes

IF YES, *please answer questions 1 – 3 below*:

1 Pads or similar

☐ No ☐ Yes (***please pick one option below***)

☐ Since before this stroke

☐ Since this stroke and still using them

☐ At first after the stroke but no longer using them

Date discontinued:

Day		Month		Year			
D	D	M	M	Y	Y	Y	Y

2 Uridom or similar

☐ No ☐ Yes (**please pick one option below**)

☐ Since before this stroke

☐ Since this stroke and still using

☐ At first after this stroke but no longer using

Date discontinued:

Day		Month		Year			
D	D	M	M	Y	Y	Y	Y

What was the reason for the use of a uridom?

3 Indwelling urethral catheter

☐ No ☐ Yes (***please tick one box below***)

☐ Since before this stroke

☐ Since this stroke and still using

Date catheterised **after this stroke**

D	D		M	M		Y	Y	Y	Y

☐ At first after the stroke but no longer using

Date catheter removed

D	D		M	M		Y	Y	Y	Y

If the patient was catheterised after admission, where was the patient when catheterised?
(***Please tick one box only***)

☐ Accident and Emergency

☐ Acute Admission Unit

☐ Stroke Unit

☐ Other (please specify below)

☐ Not documented

What was the reason for catheterisation?

Section 4: Mood and cognitive ability

1a The patient's mood

Does the patient often feel sad or depressed?
(***Please tick one box only***)

☐ Yes

☐ No

If the patient is unable to answer, use your judgement to answer question 4b below:

b Does the patient appear to have low mood?
(*Please tick one box only*)

☐ Yes

☐ No

☐ Don't know

2 Cognitive ability

Can the patient answer the six questions below either verbally or in writing?
(*Please tick one box*)

☐ Yes

☐ No

IF NO, is this because of:

☐ Stroke-related communication problems

☐ Other, please specify

IF YES, ***please complete the following:***

Please enter 0 if the patient has answered the question correctly.

If the patient has answered the question incorrectly, then the number of errors needs to be recorded.

The maximum number of errors is stated in the brackets next to each question. For questions with more than one error, please state the maximum number of errors attained by the patient.

1. What **year** is it now? (1) ☐

2. What **month** is it now? (1) ☐

Memory Phrase – Repeat after me:
John / Brown, / 42 / West Street, / Bedford

3. About what **time** is it? (within 1 hour) (1) ☐

4. **Count backwards** 20 – 1 (2) ☐

5. Say the **months in reverse** order (2) ☐

6. Repeat the **memory phrase** (5) ☐

Section 5: Experience of continence PRIOR TO stroke

Please ask the patient (or a carer/family member) these questions

Is the patient able to provide the information? ☐ Yes ☐ No

IF NO*, please write the reason below:*

____

____

***These questions ask about continence BEFORE your stroke*.**

Presence of incontinence

1 **Thinking over the last 12 months before your stroke did you ever leak urine/water when you did not mean to? That means anything from a few drops to a flood during the day or night.**
(Please tick one box)

☐ Yes

☐ No

☐ Don't know

IF YES*, please answer questions 2 to 10).* IF NO or NOT KNOWN*, go to SECTION 5)*

2 **Before your stroke, did you ever leak urine when you did any of the following?**
(Please tick all that apply)

☐ Sneeze

☐ Exercise

☐ Cough

☐ Laugh

☐ Bend

☐ Stand up

☐ Don't know

3 Before your stroke, when you had the urge to pass urine, did any leak before you got to the toilet?
(Please tick one box)

- ☐ Most of the time
- ☐ Sometimes
- ☐ Occasionally
- ☐ Never

Severity of incontinence questions

4 Before your stroke, how much did you leak usually?
(Please tick one box that best describes what happened)

- ☐ A few drops
- ☐ A dribble
- ☐ A stream
- ☐ A flood
- ☐ Don’t Know

5 Before your stroke, when you leaked urine, were you?
(Please tick one box that best describes what happened)

- ☐ Soaked
- ☐ Wet
- ☐ Damp
- ☐ Almost dry
- ☐ Don’t Know

6 **Before your stroke, how would you describe the amount of urine you leaked?**
(Please tick one box)

- ☐ Not noticeable
- ☐ Noticeable to yourself only
- ☐ Potentially noticeable to others
- ☐ Noticeable to others
- ☐ Don’t Know

Urgency questions

7 **Before your stroke, when you first felt the need to pass urine how strong was the urge to go usually?**
(Please tick one box)

- ☐ Overwhelming
- ☐ Very strong
- ☐ Strong
- ☐ Normal
- ☐ Weak
- ☐ No sensation
- ☐ Don’t know

8 **Before your stroke, did you have difficulty holding urine once you felt the urge to go? For example, what would happen if you needed the toilet and it was occupied, would you have had difficulty holding on?**
(Please tick one box)

- ☐ Most of the time
- ☐ Sometimes
- ☐ Occasionally
- ☐ Never
- ☐ Don’t know

Frequency

9 Before your stroke how many times did you go to the toilet to pass urine during the daytime?
(*Please tick one box*)

- ☐ About every half hour or more often
- ☐ About every hour
- ☐ About every hour and a half
- ☐ About every two hours
- ☐ Less often
- ☐ Don’t know

Nocturia

10 Before your stroke how often did you get up at night to pass urine, if at all?
(*Please tick one box*)

- ☐ Not usually
- ☐ Once a night
- ☐ Twice a night
- ☐ Three times a night
- ☐ Four times or more a night

10 Urinary incontinence treatment before your stroke

a) **Before your stroke, did you have any treatment for urinary incontinence?** ***(Please tick one box)***

- ☐ Yes
- ☐ No
- ☐ Don’t know

b) **Before your stroke, did you have any surgery for urinary incontinence?** ***(Please tick one box)***

- ☐ Yes
- ☐ No
- ☐ Don’t know

Section 6: Experience of continence AFTER stroke

This section is to be filled in only when the patient is not using a catheter or uridom type aid.

These questions ask about continence AFTER your stroke.

Is the patient able to provide the information? ☐ Yes ☐ No

IF NO, ***please write the reason below:***

____

____

1 Since your stroke, do you ever leak urine/water when you do not mean to? That means anything from a few drops to a flood during the day or night.

a. (Please tick one box)

☐ Yes

☐ No

☐ Not known

2 Do you ever have leak urine when you do any of the following?
(Please tick all that apply)

☐ Sneeze

☐ Exercise

☐ Cough

☐ Laugh

☐ Bend

☐ Stand up

☐ Don’t know

3 When you get the urge to pass urine, does any leak before you get to the toilet?
(Please tick one box)

- ☐ Most of the time
- ☐ Sometimes
- ☐ Occasionally
- ☐ Never
- ☐ Don’t know

4 How much do you leak usually?
(Please tick one box that best describes what happens)

- ☐ A few drops
- ☐ A dribble
- ☐ A stream
- ☐ A flood
- ☐ Don’t know

5 When you leak urine, are you?
(Please tick one box that best describes what happens)

- ☐ Soaked
- ☐ Wet
- ☐ Damp
- ☐ Almost dry
- ☐ Don’t know

6 How would you describe the amount of urine you leak?
(Please tick one box that best describes what happens)

- ☐ Not noticeable
- ☐ Noticeable to yourself only
- ☐ Potentially noticeable to others
- ☐ Noticeable to others
- ☐ Don't know

7 When you first feel the need to pass urine, how strong is the urge to go usually?
(Please tick one box)

- ☐ Overwhelming
- ☐ Very strong
- ☐ Strong
- ☐ Normal
- ☐ Weak
- ☐ No sensation
- ☐ Don't know

8 Do you have difficulty holding urine once you feel the need to go?
(For example, what would happen if you needed the toilet and it was occupied, would you have difficulty holding on?)
(Please tick one box)

- ☐ Most of the time
- ☐ Sometimes
- ☐ Occasionally
- ☐ Never
- ☐ Don't know

9 Since your stroke how many times do you go to the toilet to pass urine during the daytime?
(*Please tick one box*)

☐ About every half hour or more often

☐ About every hour

☐ About every hour and a half

☐ About every two hours

☐ Less often

☐ Don`t know

10 Since your stroke how often do you get up at night to pass urine, if at all?
(*Please tick one box*)

☐ Not usually

☐ Once a night

☐ Twice a night

☐ Three times a night

☐ Four times or more a night

11 Functional incontinence:
At the time of this assessment, is the patient:
(*Please tick all that apply)*

☐ Confined to bed

☐ Able to sit out but unable to stand unassisted

☐ Able to stand unassisted

☐ Mobile with assistance

☐ Mobile

12 Can you lift both arms off the bed?
(*Please tick one box*)

- ☐ Yes
- ☐ No

13 When you are trying to get to the toilet, are there any physical restrictions which stop you getting there on time?
(*Please tick all that apply)*

- ☐ Mobility
- ☐ Balance
- ☐ Problems using bottles/bedpans
- ☐ Other

IF OTHER*, please explain below:*

____

____

14 Can you easily manage your clothes (trousers, zips, tights etc) when going to the toilet?
(*Please tick one box)*

- ☐ Yes
- ☐ No
- ☐ Not applicable

15 Bowels

a) When did you last have a bowel movement?
(Please tick one box)

- ☐ Today
- ☐ Yesterday
- ☐ 2 days ago
- ☐ 3 days ago
- ☐ More than 3 days ago
- ☐ Not known

b) What is your normal bowel movement pattern?
(Please tick one box)

- ☐ Every day
- ☐ Every 2 days
- ☐ Every 3 days
- ☐ More than 3 days
- ☐ Not known

c) Do you normally suffer with constipation?
(Please tick one box)

- ☐ Yes
- ☐ No
- ☐ Don’t know

d) Do you feel constipated now?
(Please tick one box)

☐ Yes

☐ No

☐ Don't know

Please now turn the page, complete the Review of Assessment and decide on a treatment plan.

Review of assessment

1 Is the patient on any medication that may impact on their continence?

☐ Yes

☐ No

☐ Not sure

2 Has the patient completed the 3 day bladder diary?

☐ Yes

☐ No (patient must complete 3 day bladder diary before starting on the programme and this must be used as part of the assessment)

The continence assessment shows the patient has
(*Please tick all that apply*)

☐ Stress incontinence

☐ Urge incontinence

☐ Mixed incontinence

☐ Physical/Functional Incontinence

From the continence assessment the recommended treatment plan is:
(*Please tick one box)*

☐ Prompted voiding

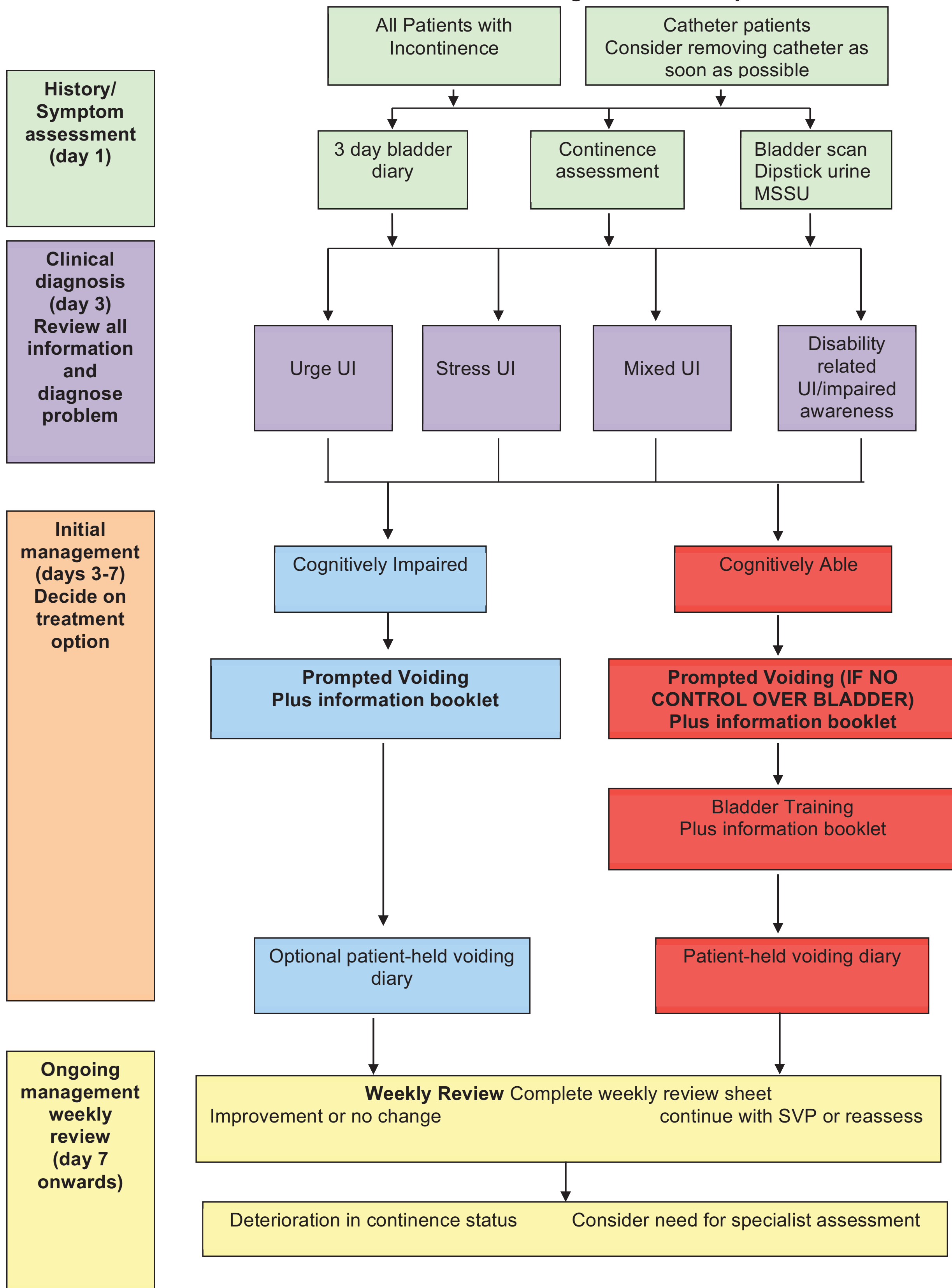
☐ Bladder training

☐ Bladder training and pelvic floor muscle training

Date started on regime: Initial voiding interval chosen:

D	D		M	M		Y	Y	Y	Y

☐


Continence Management Pathway
History/ Symptom assessment (day 1)
All Patients with Incontinence
Catheter patients Consider removing catheter as soon as possible
3 day bladder diary
Continence assessment
Bladder scan Dipstick urine MSSU
Clinical diagnosis (day 3) Review all information and diagnose problem
Urge UI
Stress UI
Mixed UI
Disability related UI/impaired awareness
Initial management (days 3-7) Decide on treatment option
Cognitively Impaired
Cognitively Able
Prompted Voiding Plus information booklet
Prompted Voiding (IF NO CONTROL OVER BLADDER) Plus information booklet
Bladder Training Plus information booklet
Optional patient-held voiding diary
Patient-held voiding diary
Ongoing management weekly review (day 7 onwards)
Weekly Review Complete weekly review sheet
Improvement or no change
continue with SVP or reassess
Deterioration in continence status
Consider need for specialist assessment