**Name: First name and Surname NHS Number: 000 000 0000**

**Address: Address of Nursing Home Date of Birth 00/00/0000**

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**Telephone No: Phone number of Nursing Home**

**Done By: Name of person completing Questionnaire Date: DateDateddddddddateddate\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. Continence Questionnaire - For use by Specialist Nurses, Registered Nurses**

 **or Band 3 HCAs and above**

 **Health Care Assistant - If triggers are hit please discuss with a Registered**

 **Nurse (you will see these triggers as you move through the questionnaire)**

1. Is the patient experiencing Bladder dysfunction?

X

 Yes No

2. Is the patient experiencing Bowel dysfunction?

X

 Yes No

3. Is a completed bladder chart attached?

X

 Yes No

4. Is a completed bowel chart attached?

X

 Yes No

5. Please describe how the patient’s bladder/bowel problems are affecting their quality of life

 and/or the quality of life of their family/carers etc.

Comments: A is unable to participate in all activities due to her incontinence. She is afraid that she smells and is reluctant to engage in social activities.

We are unable to take A out for more than one hour at a time.

6. Please assess the patient’s skin condition / pressure areas. Are there any concerns?

 What action has been taken (Pressure Ulcer Risk Assessment Tool)? Are barrier creams

 in use?

Comments: Each time A’s pad requires a change we assist her to wash, dry and apply a barrier cream.

Her skin is vulnerable but intact. It is checked at least daily by staff.

**2. Past Medical & Surgical History**

1. Past Medical & Surgical History (Smoking, Allergies, Mobility, Dexterity, Vision). Can the

 patient toilet independently? Any adaptations used? Social History, Functional/Cognitive

 ability?

Comments: A is a non smoker. She has no known allergies. She is mobile with the help of one member of staff, but can be very slow on her feet. Her vision is poor, and her hearing is assisted with the use of hearing aids.

A is forgetful and at times can be a little confused and disorientated.

 **3. Obstetric History**

1. Obstetric History (if appropriate). Number of pregnancies / births, assisted

deliveries, trauma information.

Comments: 3 children. All normal vaginal deliveries. No deliveries were assisted.

 **4. Menopausal Status**

 1. Menopausal Status (if appropriate). Vaginal dryness/ itching/ discharge, any bulging /

 prolapse?

Comments: Post menopausal (10 year +)

No prolapse noticed.

 **\*\*HCA Trigger \*\* - Does the patient need an external or vaginal examination?**

 **5. Vaginal Examination**

 1. Vaginal Examination (external or internal as per competence of assessor). Skin

 condition, visible prolapse/ condition, leakage on coughing, Pelvic Floor strength (as

 appropriate).

Comments: Skin condition around vulval area looks healthy. No irritation noticed. No discharge noticed.

1. Have you obtained consent?

 Yes No

Comments: Not done. Above observations noted when assisting with hygiene.

1. Was a chaperone present?

 Yes No

1. Add any further information regarding the chaperone e.g. patient asked but did not require a chaperone. If one was present, who was it.

Comments:

1. **Medication**
2. Medication (Prescribed and relevant to bladder/bowel function, over the counter, recreational drugs). Does the patient have a uterine coil or pessary in situ?

Comments: A takes Solifenacin 10mgs on a daily basis.

PRN lactulose for constipation. She does not require this on a regular basis.

 **\*\* HCA Trigger \*\* - Does the patient require a medication review?**

1. **Bladder/Bowel Function**

1. State the patient's reported bladder function / problems and complete a symptom profile. Include any problems with recurrent urinary tract infections and any sexual dysfunction.

Comments: A has an urgent need to get to the toilet – especially overnight. She can not always make it on time and can be at risk of leakage on the way. She also has some frequency – she can be up to the toilet 3 – 4 times overnight.

 **\*\* HCA Trigger \*\* -** **Does the patient need a bladder scan? Does this require a**

 **discussion with a registered nurse?**

 2. State the patient's reported bowel function / problems (include diet, fluids, any red

 flags?)

Comments: Occasional constipation. A drinks 1.7 litres of fluid a day. Diet is varied. She enjoys three meals a day. A eats fruit and vegetables. She is of average build.

 **\*\* HCA Trigger \*\* - Does this need discussion with a registered nurse?**

 3. What has already been done / tried and are there any current professionals involved

 with this patient's care (include urological history/treatments)?

Comments: Solifenacin was prescribed by GP in 2016. A does feel it helps with her urgency and frequency.

 4. Bladder Examination (Urinalysis - if leucocytes/nitrates are present or symptoms of

 UTI take MSU and stop assessment until treated). The presence of blood (in the

 absence of a UTI) should be referred to their GP. Fluids (amount and types),

 frequency of toileting (during the day and overnight), urgency of toileting (falls risk),

 bladder capacity, leakage of urine frequency and severity.

Comments: A has no signs of a urine infection.

She drinks around 1.7litres a day – tea, coffee and water / juice. She has always reduced her fluids in the evening – last drink around 8pm.

Frequency does not seem a problem in the day – with around 6 visits a day to the toilet. 3 – 4 visits are overnight, So this is outside ‘normal’ limits.

 5. Bladder Scan (if required)? Pre Void \_\_\_\_\_\_\_\_\_\_ Post Void \_\_\_\_\_\_\_\_\_\_

Comments: No worries about incomplete emptying.

No recurrent UTI’s.

 6. Urinalysis Result and rationale for sending MSU (if sent).

Comments: Not done.

x

 7. MSU sent? Yes No

 8. Bowel Examination (Frequency of bowel motions, type of stool, any urgency,

 incontinence of faeces, smearing/ soiling/ full stool, constipation)?

Comments: Stool chart shows a regular soft stool is passed on the toilet most days, but A does sometimes go a few days between passing bowel motions and her stool can be hard.

 9. Identify Bladder Dysfunction

 Stress Incontinence

xx

 Urgency and Frequency

 Urge Incontinence

 Incomplete Bladder Emptying

 Overflow Incontinence

 Functional Incontinence

 Catheter Related Problems

 Other – Please state below

Comments: Urgency and urge urinary incontinence. And nocturnal frequency.

 10. Treatment Offered – Bladder

 Fluid Modification

 Check Bowels

 Medication Review

 Prostate Assessment (GP)

 Toilet Facilities

 Pelvic Floor Exercises

 Bladder Retraining

 Consider Anticholinergics or Other Relevant Medication

 Appliances/Sheath

 Containment Products

 Other – Please state below

Comments: Advised to reduce caffeine – but maintain overall level of fluid intake. Advised to avoid getting constipated due to affect this can have on bladder. To continue on Solifenacin as prescribed. To consider having a commode by her bed at night. To request a containment product for the day and overnight.

 11. Identify Bowel Dysfunction

 Passive Faecal

 Urge Faecal

 Constipation

 Functional Incontinence

 Involuntary Bowel Emptying (cognitive problems)

 Other – Please state below

Comments: Only occasional constipation.

 12. Treatment Offered – Bowel

 Dietary Adjustment

 Fluid Modification

 Toileting Regime/Positioning

 Anal Sphincter Exercises

 Laxatives Requested (GP)

 Enema/Suppositories Requested (GP)

 Skin Care

 Anal Plugs/Equipment

 Containment Products

 Medication Review

 Rectal Irrigation

 Other – Please state below

Comments: To continue to take lactulose as required.

 13. What are your plans for review of treatment plan for bladder/bowel treatment?

 (Where possible please review treatment prior to requesting continence

 containment products).

Comments: Review between first delivery of products and next delivery to ensure they are suitable.

 **8. Onward Referral**

1. Does the patient require referral onwards for their bladder dysfunction?

x

 Yes No

Comments:

1. Does the patient require referral onwards for their bowel dysfunction?

x

 Yes No

Comments:

1. State what triggers are highlighted and where onward referral is required.

Comments: Not required.

 4. Does the patient require continence containment products? Consider other

 containment products such as sheath drainage systems first. If considering

 continence containment products please refer to the criteria for the provision of

 continence products and the core products that are available.

x

 Yes No

Comments:

Please may we request 3 x mini super – to be added to next Nursing Home delivery? We have gone through the fitting of the pad with the patient – but more often than not she is supervised by staff at the toilet anyway.

 5. If required, complete a Product Requirement Form. Ward staff, please refer to

 the Community staff via S.P.A. for continence questionnaires as relevant.

Comments: See attached product form

**Ward Staff Only -** Please post to Clare Markwell, Bladder and Bowel Health Service, Clifton Health Centre **(Internal Mail)**

**Nursing Homes –** Pleasecomplete on paper and send (with a product requirement form and bladder / bowel charts) to:-

Bladder and Bowel Health Service

Clifton Health Centre

Water Lane

YORK

YO30 6PS