**Name: NHS Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Done By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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?

 Yes No

2. Is the patient experiencing Bowel dysfunction?

 Yes No

3. Is a completed bladder chart attached?

 Yes No

4. Is a completed bowel chart attached?

 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:

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:

**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:

 **3. Obstetric History**

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

deliveries, trauma information.

Comments:

 **4. Menopausal Status**

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

 prolapse?

Comments:

 **\*\*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:

1. Have you obtained consent?

 Yes No

Comments:

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:

 **\*\* 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:

 **\*\* 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:

 **\*\* 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:

 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:

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

Comments:

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

Comments:

 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:

 9. Identify Bladder Dysfunction

 Stress Incontinence

 Urgency and Frequency

 Urge Incontinence

 Incomplete Bladder Emptying

 Overflow Incontinence

 Functional Incontinence

 Catheter Related Problems

 Other – Please state below

Comments:

 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:

 11. Identify Bowel Dysfunction

 Passive Faecal

 Urge Faecal

 Constipation

 Functional Incontinence

 Involuntary Bowel Emptying (cognitive problems)

 Other – Please state below

Comments:

 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:

 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:

 **8. Onward Referral**

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

 Yes No

Comments:

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

 Yes No

Comments:

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

Comments:

 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.

 Yes No

Comments:

 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:

**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