



URINARY INCONTINENCE ASSESSMENT TOOL

Directions:

1. Complete the Urinary Incontinence Assessment Tool.
2. Document the findings in the Nurses' Progress Notes.
3. Initiate an appropriate care plan.
4. Notify the appropriate support staff (PT, OT, Restorative).

Patient Information:

Primary Diagnosis _____

Secondary Diagnosis _____

Evaluation:

- Admission Significant change (change in cognition, physical ability, urinary function)

Acute onset of urinary incontinence (Identify the cause as reversible or irreversible):

Pertinent Past and Present Medical History: _____

Date of Onset: _____

Determine if any of the following conditions are present:

- | | | | |
|--|------------------------------|-----------------------------|------------------------------|
| Urinary tract infection (reversible/irreversible cause) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Polyuria associated with hyperglycemia or hypercalcemia (reversible/irreversible cause) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Fecal impaction (reversible/irreversible cause) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| New onset of acute confusion (reversible/irreversible cause) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| New onset of immobility (reversible/irreversible cause) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |
| Change in medications producing undue side effects (sedation, diuretic, urinary retention) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> N/A |

Treatment (Past or current): _____

Response to Treatment: _____

Persistent Incontinence:

Pertinent Past and Present Medical History _____

Description of urinary leakageDo you ever lose control of your urine? YES NODo you have accidents trying to get to the toilet? YES NO

How long have you had a urine leakage problem? _____

How often do you leak urine? _____

When does leakage occur? _____

When leakage occurs, how much urine leaks? _____

Do any of the following activities cause urine leakage?

- | | | |
|--|------------------------------|-----------------------------|
| a. Sneezing or coughing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| b. Laughing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| c. Bending down | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| d. Changing position from sitting, or standing | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| e. Rushing to the toilet | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| f. Running water or washing of hands | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

How often do you wear a pad, diaper, or undergarment-shield? _____

Voiding patterns

How often do you normally urinate? _____

When you bladder becomes full, how long can you hold your urine? _____

Do you get up at night to urinate? YES NO

Does any of the following occur during urination?

a. Difficulty in getting urine started YES NO

b. Slow stream of dribbling YES NO

c. Discomfort or pain YES NO

d. Blood in urine YES NO

e. Burning sensation YES NO

f. Feeling that your bladder did not empty completely YES NO

Are you currently using an aid of any type to help with urinary leakage? YES NO

Fluid Intake

How many glasses of fluid do you drink each day? _____

How much fluid do you drink within two hours of going to bed? _____

Do you drink coffee, tea, or soda products with caffeine? YES NO

Bowel Control

Frequency of stool: _____

Uncontrolled loss of stool. Identify frequenc _____

Need to utilize laxatives and /or enemas. Identify frequency of us _____

Straining during bowel movement. YES NO

Medications

List medications which may adversely affect urinary frequency: (e.g., diuretics, antihypertensives, sedation, pain medications, other drugs affecting the autonomic nervous system).

Mental Status

Normal Mild/Moderate cognitive impairment Severe cognitive impairment (unaware of toileting needs)

Mobility

- Ambulates independently.
- Ambulates independently but slowly.
- Does not ambulate independently but is able to utilize urinal, bed pan or bedside commode independently.
- Chair or bed bound but is able to utilize urinal or bed pan independently.
- Dependent on staff for toileting.

Additional Information

Do you smoke cigarettes? YES NO

How much do you smoke? _____

How long have you smoked? _____

Evaluations

- Physical examination and evaluations by physician. YES NO
- Ancillary evaluations by PT, OT for environmental factors and assistive devices. YES NO
- Skin assessments. YES NO
- Diagnostic testing (e.g., Voided volumes, post void residual, urinalysis, urine culture). YES NO

Treatment Approaches

- Treat reversible factors.
- Treat for urge incontinence.
- Treat for stress incontinence.
- Treat for mixed incontinence.
- Manage supportively.

Care Planning

The care plan should be based upon the goals, needs and strengths specific to the resident and reflects the comprehensive assessment. Care plan revisions should be based upon the outcome and/or effects of goals and interventions, a decline or lack of improvement in continence status, and changes in resident conditions such as the ability to make decisions, cognition, medications, behavioral symptoms or visual problems.

Care Plan Outline

- Identify quantifiable, measurable objectives with time frames;
- Identify interventions specific enough to guide the performances of the services;
- Identify resident choices and preferences;
- Promote and maintain dignity;
- Identify psychosocial complications of incontinence or catheterization and their interventions;
- Identify the educational component for the resident regarding incontinence and catheter use;
- Identify appropriate measures for sufficient fluid intake;
- Identify interventions to prevent skin breakdown;
- Identify risks for infection and the appropriate interventions;
- Identify medications putting residents at risk for incontinence and the appropriate interventions;
- Identify environmental factors and devices which promote resident independence;
- Identify individualized toileting program and the appropriate approaches related to specific types of incontinence; and
- For residents with a catheter identify the catheter protocol, assessment and removal protocol, and interventions to minimize any injury to the resident.

Signature of Clinician completing assessment

Date

UNINARY INCONTENECE ASSESSMENT TOOL, continued

Sample Bladder Record (Should be tracked for 24-hour time period for several days)

Time Interval	Urinated in Toilet	Incontinent Episode (Small/Large)	Reason for Incontinent Episode	Type and Amount of Liquid Intake	Bowel Movement	Pad/Diaper Use
7 a.m. – 8 a.m.						
8 a.m. – 9 a.m.						
9 a.m. – 10 a.m.						
10 a.m. – 11 a.m.						
11 a.m. – 12 Noon						
12 Noon – 1 p.m.						
1 p.m. – 2 p.m.						
2 p.m. – 3 p.m.						
3 p.m. – 4 p.m.						
4 p.m. – 5 p.m.						
5 p.m. – 6 p.m.						
6 p.m. – 7 p.m.						
7 p.m. – 8 p.m.						
8 p.m. – 9 p.m.						
9 p.m. – 10 p.m.						
10 p.m. – 11 p.m.						
11 p.m. – 12 a.m.						
12 a.m. – 1 a.m.						
1 a.m. – 2 a.m.						
2 a.m. – 3 a.m.						
3 a.m. – 4 a.m.						
4 a.m. – 5 a.m.						
5 a.m. – 6 a.m.						
6 a.m. – 7 a.m.						

Above adapted from: Urinary Incontinence in Adults: Acute and Chronic Management: Clinical practice Guideline #2 (1996 Update), AHCPR Publication Number 96-0682, March 1996