Royal College of Nursing

CONTINENCE CARE IN CARE HOMES

A framework to gather and share key information

working together

Resident's name

Publication Code 003 139

working together

Name of care home

Resident room number

Date of birth of resident

First language

Date of admission to care home

Date continence care framework commenced

Named Nurse

Key worker

General Practitioner (GP)

Other relevant assessments	Completed yes	No	Date completed	Score	Review Date	Score
Waterlow						
Barthel						
Mini Mental						
Other (please name)						

Why do you need this document?

A framework to gather and share key information

Continence care in care homes

A 2005 RCN continence care in care homes audit identified a number of key issues relating to the delivery of continence care within care homes. Evidence of assessment and planned continence care was often difficult to find and often did not reflect the true nature of the care being delivered.

In partnership with representatives from care homes across England a continence care framework has been developed. The framework will guide staff in gathering appropriate clinical information in order to develop a continence care plan.

The framework lists a number of key questions to ask or suggests what information to gather if a resident has a bladder or bowel problem. The list is not exhaustive but will guide the process. The format used allows all information to be recorded in a standardised way and stored together for easy access.

This framework consists of four sections

- A list of key questions to ask (gather information) about the resident's bladder and bowel control . Examples of different aspects to explore are given although the list is not exhaustive, section 1, pages 1 to 10.
- Documentation to record this information, section 1, pages 1 to 10.
- Documentation to plan and review continence care for the individual resident in a format linked to the key questions /information gathered, section 2, pages 1 to 10.
- Brief information on the different aspects of continence care to enable you to provide good quality continence care in the form of "top tips", pages 11 to 14.

This format allows all information to be recorded in a standardised way and stored together for easy access.

Continence problems are common in care homes. This is distressing for the resident concerned and time consuming for staff. It can also result in an incontinence odour in the home. To provide good quality continence care, finding out why the resident has a bladder or bowel problem, putting an care plan in place and reviewing the care delivered is essential. This can be a very rewarding process for the resident and staff.

Whilst many policy documents use the term service user, this document uses the term resident. This decision was made in response to comments made by care home staff during the development phase.

Introduction

A framework to gather and share key information

Continence care in care homes

The continence assessment must be carried out by staff with the appropriate knowledge and skills. Information can be gathered through a variety of sources. Listening to the resident in a private place using an open empathetic approach and appropriate questioning will reveal the problem from the resident's perspective. Past bladder and bowel problems and any treatment or specific care that has been given in the past can be confirmed by again talking with the resident. You may need to involve relatives and past carers in this discussion (with the resident's consent). Nursing and medical notes should be consulted.

Gathering information is an ongoing process. It is highly unlikely you will gather all the information you need during one consultation, regardless of the assessment tool you use. It will take time to gather all of the necessary information to build a comprehensive picture of your resident's individual needs. Specific clinical observations may be required to back up the resident's descriptions of symptoms and eliminate some common causes/ contributory factors to the problem.

A partnership approach is likely to achieve the best results. Active participation from the resident (and/or relative/advocate) in the assessment process and care planing will ensure all parties are clear about what is to be done, by whom, when and where. Expectations or goals regarding bladder and bowel care should be decided with the resident and/or relative/advocate. This, alongside information gathered, should be documented, shared with the health care team and used to develop the continence care plan. Regular review is required to ensure changing clinical needs are addressed.

Your local continence service can be contacted for further help and advice should it be required.

LOCAL CONTINENCE ADVISOR	CONTACT DETAILS

The document is divided into two sections. Section 1, essential information to gather, has the key questions to ask. Underneath each question is a list of prompts, these are intended to provide the assessor with some guidance as to what they may need to be asking the resident. The list of prompts is not exhaustive and you may need to adapt the prompts for your specific care home.

Section 2, care planning and evaluation. This section provides an area for you to plan care based on the information you have gathered in section 1. You may not need to plan care for all questions. Top tips are available to support your care planning process.

The purpose of the document being in two distinct sections is to ensure continence assessments are not treated as 'tick box' exercises. We need to gather information and once all the necessary information is available, plan care that best meets the resident's specific needs.

Gathering information can take time. All members of the team should be involved in information gathering process and healthcare assistants can be encouraged to document information they have obtained in Section 1.

Section 1

essential information to gather

Section 2

care planning & evaluation

As the assessment progresses a care plan must be made. This Care Plan may be planned in stages as information is gathered. Each stage should be documented, dated and when completed review dates set. All staff must be aware of the planned care and have easy access to the documentation.

Section 1

key questions to ask

Q1. What problems does the resident experience with bladder or bowel control?

- Frequent visits to the toilet (day or night)
- Uncontrollable leakage (day or night)
- Pain on passing urine or opening bowels
- Frequent infections
- Blood in the urine or when opening bowels
- Having to strain excessively to open bowels
- Feels like bladder or bowels are never fully emptied
- Complaints of abdominal discomfort or pain
- Not getting to the toilet in time (finds it difficult to hold on)
- Having to strain or push on the tummy to start passing urine
- Poor urine stream
- Difficulties getting urine stream started
- Dribbling after having passed urine
- Constant wetness or soiling

Q2. When did the problem start?

- Before admission to care home (Sought treatment)
- Before admission to care home (Has never sought any treatment)
- After admission to care home
- After a surgical procedure
- During an episode of ill health
- Following a fall

What is the residents past medical history?

- Parkinson's Disease
- Multiple sclerosis
- Previous Urological surgery
- Previous colorectal surgery
- Any allergies
- Previous gynaecological surgery
- Stroke
- Arthritis
- Spinal injuries
- Diabetes
- Skin conditions
- Other

Q3. When does the problem occur?

- At any particular time of the day
- At any particular time of the night
- Only when getting out of the chair or bed
- Only on the way to the toilet
- When coughing or laughing
- When anxious

You will need to monitor urine output for at least 3 days. A variety of monitoring charts are available free of charge from various companies. A suggested format for a chart is at the back of the framework

Section 2

plan your care here questions 1,2 & 3

CONSULT TOP TIP 1 & 3 ON PAGE 11 & 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

✎ Describe the residents bladder problem

✎ Describe the residents bowel problem

✎ Document when the problem started, including any previous assessment and treatment results and past medical history

✎ Describe when the problem occurs

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Section 1

key questions to ask

Q4. Has the resident had their urine tested?

- Is the urine cloudy or smelly
- Does the urine appear concentrated (dark orange/yellow in colour)
- Can you see any blood in the urine

Local policy should be followed when sending a Mid-Stream specimen of Urine (MSU) to confirm the presence of urinary tract infection

Q5. What is the residents typical bowel pattern?

- Opens bowels with no difficulties
- Has to strain to open bowels
- Requires prescribed laxative regime
- Self evacuation techniques used
- Is the stool excessively hard or soft (consult Bristol Stool Chart)

In order to gather the correct information it may be necessary to monitor the residents bowel habits over a short period of time. This should be done with the consent of the resident

Section 2

plan your care here questions 4 & 5

CONSULT TOP TIP 4, 5, 6, 7 & 8 ON PAGE 12,13 & 14

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

DATE	TEST	RESULTS
	Observation of urine (colour, blood & odour)	
	Routine urinalysis	Ph Sg Blood Glucose Nitrites Leucocytes
	MSU	

DATE	INFORMATION REQUIRED	INFORMATION GATHERED
	Frequency of bowel emptying	
	Do they strain or push	
	Self evacuation techniques eg digital stimulation, manual evacuation	
	Do they take laxatives, If yes please list here	
	Consistency of stool (refer to Bristol Stool Chart)	

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Section 1

key questions to ask

Q6. How does the resident feel about their bladder or bowel problem?

- Anxious
- Upset
- Depressed
- Appears unconcerned
- Keen to get problem 'sorted out'

Q7. What current strategies are used to manage any bladder or bowel problems?

Careful questioning is required to identify if your resident is reliant on any of the following strategies to maintain or control their continence problem.

- Going to the toilet frequently
- Reducing fluid intake
- Adapting food intake
- Sitting near to the toilet
- Staying in room
- Avoiding social activities
- Wearing pads "just in case"
- Staying in nightclothes / not wearing underwear
- Uses disposable/re-usable continence products

Q8. What are the residents views on participating in developing a action plan?

- Actively seek residents views
- Discuss willingness to participate
- Consult relatives / advocate where appropriate
- Assess cognitive ability to participate in process

Section 2

plan your care here questions 6,7 & 8

CONSULT TOP TIP 6, 7 & 8 ON PAGE 13 & 14

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

✎ Document residents views

✎ Document current strategies used, if pads used state type and amount used in 24 hours

✎ Residents views

✎ Relatives views (if appropriate)

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Section 1

key questions to ask

Q9. How does the resident get to the toilet?

- Gets out of chair / bed unaided / aided
- Walks safely unaided / aided
- Walks with assistance / equipment
- Transferred in a wheelchair
- Requires hoisting
- Remains in bed
- Day and night variances

Q10. How does the resident use the toilet?

- Unaided
- With assistance from staff
- Requires support equipment eg raised toilet seat, urinal
- Uses commode in room
- Never uses toilet
- Day and night variances

Section 2

plan your care here questions 9 & 10

CONSULT TOP TIP 2 & 3 ON PAGE 11 & 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

✎ Describe the way in which the resident gets to the toilet

✎ How does the resident use the toilet?

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Section 1

key questions to ask

Q11. Does the resident have any health problems which affect mobility & dexterity?

- Arthritic joints
- Stiffness
- Pain
- Breathlessness
- Dizziness
- Weakness
- Paralysis
- Foot problems – toe nails, bunions etc

Q12. Are there any environmental factors that maybe contributing to the residents

- Shared rooms
- Chair height
- Bed height
- Toilet height
- Toilet location and environment – warm, well lit, clean and private
- Floor surfaces – non-slip, non-shiny
- Signage
- Availability of staff – day and night variances
- Availability of appropriate and individual equipment
- Clothing which enables the resident and staff who maybe assisting to access and use toilet with ease.

Section 2

plan your care here questions 11 & 12

CONSULT TOP TIP 2 & 3 ON PAGE 11 & 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

HEALTH PROBLEM	IMPACT ON RESIDENT
EXAMPLE Has arthritis in hips and shoulders. Results in pain and limited range of movement	Painful to sit on toilet, painful to stand from toilet. Extreme pain if hoisted. Difficult to adjust clothing and wipe self after using toilet

bladder or bowel problems?

ENVIRONMENTAL FACTOR	EFFECT ON RESIDENT
EXAMPLE Mrs Jones does not like to use toilets near the lounge as they do not lock'	Requests to go to toilet in own room but finds sometimes this takes to long and she is wet before she gets there

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key questions to ask

Q13. Is resident able to verbally communicate the need to use the toilet?

- Do they ask to use the toilet
- Words used for passing urine
- Words used for opening bowels
- Words used to describe toilet
- Is this method of communication understood by all staff

Q14. In the absence of verbal communication does the resident have other

- Consult relatives as appropriate
- Hand signals
- Facial expressions
- Restless behaviour
- Picture cards
- Touching 'down below'
- Is this method of communication understood by all staff

Q15. Does the resident have any visual or hearing problems?

- What methods do they use to attract the attention of staff
- What methods do staff use to communicate with resident
- Are appropriate aids being used eg flash cards
- Are toilet signs appropriate for this resident eg large pictures
- Note any conditions such as glaucoma as this may influence decisions to prescribe certain medications to treat overactive bladder

plan your care here questions 13,14 & 15

CONSULT TOP TIP 2 & 3 ON PAGE 11 & 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

✎ If yes document residents preferred words

ways of communicating their need to go to the toilet?

✎ Document methods used by resident to communicate the need to use toilet

✎ Document residents specific problems

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key questions to ask

Q16. Does the resident display any memory/confusion/behavioural problems?

- Forgets when last used toilet
- Needs prompting to use toilet
- Does not recognise toilet
- May use inappropriate object instead of toilet (bins)
- Wanders
- Aggression
- Smearing / parcelling
- Hiding underwear

plan your care here question 16

CONSULT TOP TIP 2 & 3 ON PAGE 11 & 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

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PROBLEM	REASONS TO CONSIDER
EXAMPLE resident continually wandering	resident may be experiencing difficulties finding the toilet

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key questions to ask

Q17. What is the residents typical dietary intake?

- Amount and type of fluid drunk during the day
- Amount and type of fluid drunk during the night
- Any assistance required with eating and drinking
- Do they take any specialist diet?
- Are there any concerns about appetite and amount of food eaten
- How does resident communication desire for food or drink are there any specific medical problems which will affect the residents dietry intake

A variety of documents are available for you to record information regarding the residents dietary intake. As a minimum at least three days information regarding fluid intake must be recorded. This can be documented on a simple intake and output chart, an example of which is given at the back of this framework.

Fluid Intake Matrix - to determine suggested intake per 24 hours

PATIENTS WEIGHT STONE	PATIENTS WEIGHT KG	MIS PER DAY	FLUID OZ	PINTS	MUGS
6	38	1190	42	2.1	4
7	45	1275	49	2.5	5
8	51	1446	56	2.75	5-6
9	57	1786	63	3.1	6
10	64	1981	70	3.5	7
11	70	2179	77	3.75	7-8
12	76	2377	84	4.2	8
13	83	2575	91	4.5	9
14	89	2773	98	4.9	10
15	95	2971	105	5.25	10-11
16	102	3136	112	5.5	11

This matrix should be used broadly as a guideline, and applies to body frame. Gross obesity should not be a reason for increasing fluid intake. Activity levels should also be taken into account.

Ref: Abrams & Klevmark. Frequency volume charts an indispensable part of urinary tract assessment. 1996 Scandinavian Journal of Neurology 179;47-53

plan your care here question 17

CONSULT TOP TIP 4 ON PAGE 12

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

document your information here

DATE	INFORMATION REQUIRED	INFORMATION GATHERED (You will need to complete the input / output chart for 3 days). See back of pack
	Record how many drinks and type are taken in a typical day (only record actual amounts drunk) For example, 10am Cup of tea offered. 150 mls taken.	
	Record how many drinks and type are taken in a typical night (only record actual amounts drunk).	
	Record specialist diet , appetite concerns or oral problems (eg dentures or sore mouth) For example, soft diet, liquidised diet, tube feeding. Supplements used, prompting required, etc.	
	Any particular likes / dislikes. How do they communicate desire for food or drink. For example, prefers cold drinks, likes to eat in own room.	
	Describe any assistance needed. For example, encouragement to eat and drink, help to lift cup, use of adapted cups or cutlery, etc.	

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key questions to ask

Q18. What medication does the resident take?

- List all medication taken, including herbal remedies and 'over the counter' preparations
- Consider the effect these medications may have on bladder and bowel function
- Has the resident had a recent medication review?
- Review medication with GP if medication has possible effects on bladder or bowels

plan your care here question 18

CONSULT TOP TIP 5 ON PAGE 13

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

DATE	DRUG NAME & DOSAGE	POTENTIAL EFFECT ON BLADDER & BOWEL FUNCTION
EXAMPLE	Frusemide 20mg once per day	Will increase the number of visits to the toilet and make it more difficult to 'hang on'

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key questions to ask

Q19. Does the resident require any specific physical examination?

- Pushing and straining to pass urine may indicate difficulties in emptying the bladder (Post void ultrasound scan may be required)
- Pushing and straining to pass urine in the male may indicate difficulties in emptying the bladder due to an enlarged prostate gland(Post void ultrasound scan may be required along with a rectal examination to assess the extent of the problem)
- Pushing and straining to emptying the bowels may indicate constipation – Digital rectal examination performed by appropriately trained personnel may be required.
- Constant faecal smearing in the residents underwear may indicate constipation - Digital rectal examination performed by appropriately trained personnel may be required.
- Red, dry skin and discharge in the vulval area may indicate the need for more specialist examination to diagnose atrophic changes or vaginal infections.
- Female residents complaining of dragging and discomfort in the vaginal area. (examination to diagnose possible prolapse)
- Constant dribbling of urine may indicate the bladder is not emptying completely - (Post void ultrasound scan may be required)

All of the above symptoms warrant further investigation – contact your GP or local continence service for further advice.

plan your care here question 19

CONSULT TOP TIP 7 & 8 ON PAGE 14

DATE	PROBLEMS IDENTIFIED	CARE / ACTION PLAN	STAFF SIGNATURE AND REVIEW DATE

DATE	EXAMINATION	RESULT
29/12/06 10am	Dr Jones performed rectal examination EXAMPLE	Prostate soft and enlarged. Dr Jones will refer Mr Smith to Urology outpatients

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Top tips

A framework to gather and share key information

Top Tips 1 – healthy Bladder and Bowel – Contributory factors

Contributatory factors can be wide ranging and specific to the individual. These factors must be addressed in order to obtain the best outcome for the resident.

- Untreated, symptomatic urinary tract infections must be identified and treated.
- Urinary frequency and urgency may be due to undiagnosed diabetes. Urine testing is essential.
- Incomplete bladder emptying may be a complication of diabetes, diabetics experiencing urinary tract infection or dribbling urine must have a post void bladder scan.
- A loaded rectum may cause urinary symptoms.
  Neurological diseases such as Stroke, Parkinson's disease and Multiple Sclerosis impact on both bladder and bowel function. Constipation and incomplete bladder emptying occur frequently in these conditions.
- An overactive bladder causes urinary frequency and urgency. The resident may pass small volumes of urine, this can occur by day and night and may cause urge incontinence. This can be treated by bladder training programmes or by anticolenergic medications.
- Stress incontinence occurs predominately in women causing small amounts of urine to be lost on physical exertion such as coughing, sneezing or getting out of a chair. Obesity, constipation and a chronic cough will make the problem worse. It can be treated in some women with pelvic floor exercises, medication or surgery.
- Overflow incontinence can be caused by an enlarged prostate gland in men, diabetes and severe constipation in both men and women. Symptoms include recurrent urine infection, dribbling of urine, difficulty in starting the stream of urine , a poor stream of urine and passing small amounts of urine. Treatment will depend on the cause.
- Nocturia (passing large amounts of urine at night) may indicate heart failure or reduced secretion of the antidiuretic hormone. Medical assessment is required.
- **Staff having an unsympathetic attitude towards residents bladder and bowel needs will have an adverse effect on all aspects of continence care within the care home.**

Top Tips 2 – Healthy Bladder and Bowels – Functional Issues

- The functional assessment considers the resident's journey from communicating their need to use the toilet, getting to and using the toilet, and returning to their seat or bed.
- Always ensure the height of the chair and bed is appropriate for the resident's ability to get out of them.
- Enable the resident to mobilise safely to the toilet. Use specialist equipment when required, for example walking frames, sticks etc.
- Ensure clothes are easy to manage. Consider use of adapted clothing or easy to mange styles.
- Ensure the resident is able get on and off the toilet safely. Provide any equipment or help necessary to achieve this.
- Enable resident to sit and use the toilet safely and in comfort.
- Ensure resident can wipe/clean self, and wash hands after using toilet. Provide any help or equipment necessary to achieve this.
- Ensure help/adaptations/equipment are in place for both day and night. Allow for day and night time variances.
- Ensure all toilets are warm, clean, comfortable and private.
- Wherever possible involve both occupational therapists and physiotherapists in this process.
- **Remember unresolved functional issues can lead to falls and fractures as well as causing or worsening incontinence.**

Top tips

A framework to gather and share key information

Top Tips 3 – Healthy Bladder and Bowel – Cognitive Issues

It should never be assumed that bladder and bowel problems are a direct result of cognitive problems although they may well be a contributing factor.

- Depression may decrease a resident's motivation to use the toilet. Appropriate encouragement should be given.
- Medication used to treat the depression may cause constipation. Appropriate laxative therapies may be required.
- Memory problems may lead to urinary frequency as the resident forgets they have used the toilet and repeats the visit. Residents may also forget why they have gone to the toilet and leave before they have used it. Gentle prompting and supervision is required.
- Confusion may prevent the resident from identifying the toilet, appropriate sign posting will be required.
- Residents with dementia may be frightened to sit on the toilet. Help may be available from Community Mental Health Teams in devising appropriate regimes.
- Residents with dementia or confusion may loose the ability to communicate the need to use the toilet. Staff will need to learn to recognise behaviour which indicates the need to use the toilet and act accordingly. Behaviours may include wandering, pulling at clothing or agitation.
- Residents who no longer recognise the need to use the toilet may benefit from prompted / indivualised toileting regimes.
- **Severe behavioural problems related to continence in residents who have dementia type illnesses may need input from specialised services including psychology and mental health teams.**

Top Tips 4 – Healthy Bladder And Bowel – Food And Drink

Diet and fluid intake play an important role in maintaining healthy bladder and bowel function. The fluid intake and dietary charts may help you identify any areas of concern.

- The amount of fluid needed over a 24hr period will vary from resident to resident. You may find in useful to use a fluid matrix, which guides fluid intake based on the body weight of the resident.
- Be aware of early signs of not drinking enough, such as unfinished drinks, headaches, lethargy, concentrated urine and disorientation.
- Drinks and foods preferred by the resident should be made freely available.
- Fluid intake should be fairly constant throughout waking hours. Residents who take large amounts of fluid immediately before going to bed may benefit from adjustment.
- Provide appropriate drinking and eating equipment and give appropriate help required for food and drink to be consumed.
- Keep a fluid input and out put chart and food diary if there is any doubt that an adequate amount of food and drink is being consumed.
- Document and ensure that any special diet required is available and consumed.
- Ensuring assessment of any swallowing problems, documenting and following advice/exercises that may be given. Offering alternatives such as jelly, ice cream, soup, yogurt, and custard. Considering thickening powder for drinks.
- A varied, balanced and sufficient diet that has an appropriate fibre content should be provided.
- As drinks containing caffeine such as coffee may worsen urinary frequency and urgency in some residents, de-caffienated substitutes may be tried and their effectiveness in reducing symptoms evaluated. Dependence on caffeine is apparent in many people therefore withdrawal of caffeine containing drinks should be carried out over a period of time.
- Alcohol and artificial sweeteners may worsen or cause urgency, frequency and an increased need to empty the bladder during the night in some residents.

Top tips

A framework to gather and share key information

Top Tips 5 – Healthy Bladder and Bowel – Medication

The effects of some medication can cause significant difficulties with bladder and bowel control. However it should also be remembered that medication can be used successfully to treat bladder and bowel conditions.

- Staff should be aware of medication that can cause or worsen bladder or bowel problems and monitor residents.
- Medication that may be affecting the bladder or bowel problem may need to be changed or given at a different time of day, for example diuretics.
- Night sedation can cause incontinence in some residents. Review and change if necessary.
- Pain killers may cause constipation in some residents, review and ensure appropriate laxative therapy is prescribed as indicated.
- Treatment for urinary incontinence caused by an overactive bladder may be treated with conservative measures and anticolenergic medication.
- Anticolenergic medication should be used with caution in residents with cognitive problems.
- Topical oestrogens can be used to treat atrophic vaginitis, in some female residents.
- Laxatives will help constipation but other management strategies, such as abdominal massage may also be put in place.
- Diuretics given early evening may help address nocturia polyuria (passing large volumes of urine during the night).
- **All medications and their effect must be reviewed regularly.**

Top Tips 6 – Healthy Bladder And Bowel – Constipation Management.

The most common cause of faecal incontinence is constipation, it can also cause or worsen urinary incontinence. It can cause lethargy, nausea, loss of appetite and abdominal pain.

- Ensure all staff understand the way each resident communicates their need to have their bowels opened so that the toilet is provided for use immediately the urge to open the bowels is felt.
- Ensure correct position on the toilet , feet supported and toilet adaptations are in place to suit the individual needs of the resident.
- Ensure the toilet is private, warm and clean and your resident has time and privacy to sit undisturbed on the toilet to empty their bowels.
- If laxatives are prescribed for the individual residents, this should be documented in nursing records, given as prescribed and its effect reviewed regularly.
- The Bristol Stool Chart should be used to describe consistency of stool.
- A varied, balanced and sufficient diet that has an appropriate fibre content should be provided.
- Exercise such as gentle walking may help stimulated bowel action in some residents. Even exercises performed while sitting in a chair may help.
- Episodes of faecal incontinence must be carefully monitored to ensure the resident does not have constipation with overflow.
- Faecal incontinence may require specialist advice and treatment. Appropriate skin care must be adhered to in cases of ongoing faecal incontinence.
- **Any change in usual bowel habit , pain on defecation , rectal bleeding or blood noted in stools should be reported to medical staff at once.**

Top tips

A framework to gather and share key information

Top Tips 7- Healthy Bladder and Bowel – Physical Examinations

Some physical examinations may need to be part of your information gathering process. These should be carried out by the staff with the appropriate knowledge and skills.

- Anyone performing examinations such as rectal examination, bladder scanning or vaginal examination must ensure they are competent to perform the procedure. This includes ensuring training received is current and appropriate. The practitioner must be able to demonstrate evidence of updating.
- Local continence services should be contacted to discuss any training requirements.
- Residents with neurological diseases such as Parkinson's disease or Multiple Sclerosis are at high risk of developing incomplete bladder emptying. Post void bladder scanning is highly recommended in these residents.
- Urinary symptoms such as constant dribbling or recurrent urinary tract infections may indicate incomplete bladder emptying. Post void bladder scanning is highly recommended in these residents.
- Local continence services can give advice as how to arrange for a post void bladder scan to be carried out.
- Male residents who experience urinary symptoms require rectal examination to exclude prostatic disease. This can be arrange via the residents local GP or continence service.
- Residents with severe constipation may require both rectal and abdominal examinations to assess the severity of the problem.
- Female residents with any vulval skin changes need medical assessment. Treatment such as topical oestrogen may be indicated.
- Female residents who have obvious signs of genital prolapse should be assessed by an appropriate practitioner.
- **All results of any physical examination and the planned care should be recorded and regularly reviewed.**

Top Tips 8 – Healthy Bladder and Bowel – Urine testing

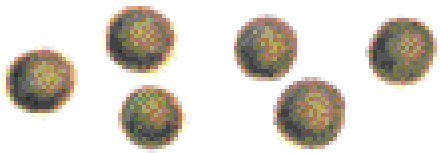
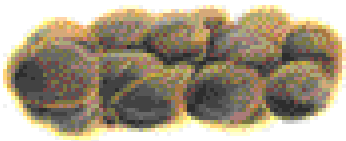
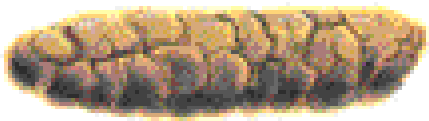
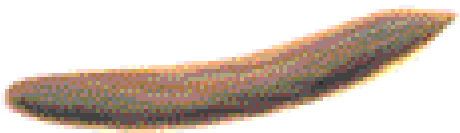
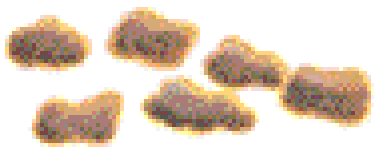
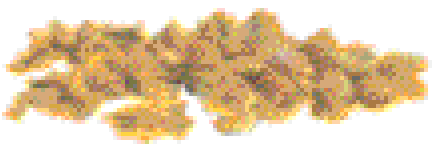
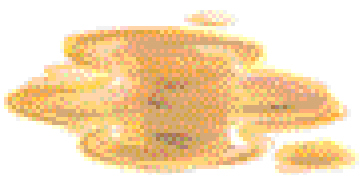
Urine testing is an essential requirement when assessing and treating bladder problems

- A resident's urine should be tested by dip stick on admission for possible infection or diabetes
- It should also be tested if the resident has concentrated, smelly or cloudy urine to check for infection.
- It should also be checked if the resident becomes confused or more confused than usual, is lethargic, generally unwell or running a temperature.
- The dip sticks used should be within the expiry date and should have the facility to show if any leucocytes or nitrates are present in the urine.
- The presence of leucocytes, nitrates and /or blood indicates infection and a clean specimen of urine should be sent to the Path Lab for further analysis.
- The presence of blood alone indicates a need for further analysis at the Path Lab.
- The presence of glucose should be recorded and reported to the GP for further action.
- Symptoms of a urine infection should direct the treatment.
- If a resident has recurrent urine infections a bladder scan to check if the bladder is emptying effectively should be carried out . Consult your local Continence Service.
- **All staff performing urinalysis should ensure they are competent to perform the task. Advice regarding training in urinalysis can be obtained from local continence services.**

Bowel Diary

Date and time				
Did the resident have to rush to the toilet? (Urgency)				
Did the resident have to push excessively to open their bowels? (Straining)				
What was the consistency of the stool? (Consult Bristol stool chart)				
Did the resident have any faecal leakage?				
Any other information, such as pain on opening bowels, bleeding or feeling of incomplete bowel emptying				

THE BRISTOL STOOL FORM SCALE

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

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Intake & Output Chart

TIME	DAY 1			DAY 2			DAY 3		
	Intake	Output	Other Info Document pad changes, wet clothes or bedding. Also changes in behaviour such as restlessness or agitation which may indicate a need to use the toilet	Intake	Output	Other Info Document pad changes, wet clothes or bedding. Also changes in behaviour such as restlessness or agitation which may indicate a need to use the toilet	Intake	Output	Other Info Document pad changes, wet clothes or bedding. Also changes in behaviour such as restlessness or agitation which may indicate a need to use the toilet
07.00									
08.00									
09.00									
10.00									
11.00									
12.00									
13.00									
14.00									
15.00									
16.00									
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23.00									
24.00									
01.00									
02.00									
03.00									
04.00									
05.00									
06.00									
Totals									