

# BOWEL AND URINARY CONTINENCE CARE PATHWAY - Primary Assessment

NAME: .....

NHS No:

Hospital No:

D.O.B: ..... Male ☐ Female ☐

**How does your bladder/bowel problem affect your life? e.g. socially, physically, psychologically.**

How much does your bladder/bowel problem bother you? (*circle the choice*)

**A LOT      MODERATELY      A LITTLE      NOT AT ALL**

INITIAL ONLY IF VARIANCE FROM STANDARD STATEMENT			
STANDARD STATEMENT	VARIANCE FROM STANDARD STATEMENT AND REASON / COMMENTS	Date	Initial
Patient drinks _____ amount of fluid per day and type. Refer to fluid matrix.			
If a patient drinks volumes outside parameters of fluid matrix, advise them to drink appropriate amount.			
Urinalysis performed:			
GLUCOSE			
KETONE			
S.GRAVITY			
BLOOD			
PH			
PROTEIN			
NITRITE			
LEUCOCYTES			
If leucocytes/nitrite or symptoms of UTI present, take MSU, inform doctor and discontinue this assessment until treated.			
Exclude constipation or bowel problems/faecal incontinence. Give appropriate advice such as 'Constipation leaflet'. Refer to doctor as necessary for physical examination or commence care pathway.			
Review medication from list provided. Consider review by doctor.			
Patient has no mobility dexterity or environmental problems.			
Patient has no signs of cognitive dysfunction or give 'Continence in the Confused Elderly' sheet to patient/carer			
Symptom Profile has been completed with patient/carer.			
According to findings from Symptom Profile and having excluded the above possible reversible causes for incontinence, commence appropriate Care Pathway.			

**PLEASE FILE IN INPATIENT SECTION OF PATIENT NOTES**

# BOWEL AND URINARY CONTINENCE CARE PATHWAY - Primary Assessment con'td

NAME: .....									
NHS No:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Hospital No:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D.O.B: .....	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>					

SYMPTOM PROFILE FINDINGS:

**Profile No.1** indicates stress incontinence

**Profile No.2** indicates urge incontinence

**Profile No.3** indicates overflow

**NB:** Some clients may experience mixed incontinence i.e. urge and stress incontinence. Both pathways therefore need to be followed e.g. Patient Profile No. 1 and No. 2

Please state reason below if patient does not wish to commence a care pathway:

**NB: If no care pathway commenced, return this assessment with Product Request Form if appropriate to:**

Continence Advisory Service, Isaac Maddox House, Shrub Hill Road, Worcester. WR4 9RW **OR**  
**for patients with a Warwickshire GP i.e. Studley return to:**  
 South Warwickshire Continence Service, Royal Leamington Spa Rehabilitation Hospital,  
 Heathcote Lane, Leamington Spa. CV3 46SR

## TO BE COMPLETED BY ALL STAFF USING THE PATHWAY

**SIGN THAT YOU HAVE MET ALL STANDARDS OR RECORDED VARIANCES**

FULL NAME	DESIGNATION	INITIALS	SIGN	DATE