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Continence Containment Assessment & Management Plan

Client Info

Continence Containment Assessment

Continence Issue: ☐ **Urine** ☐ **Fecal** ☐ **Both**

Duration of issue: ☐ Recent within last 3 weeks: ☐ Gradual ☐ Sudden
☐ Recurring
☐ Longstanding (e.g., months/years, # if known) ____

If Urine: Burning on voiding: ☐ Yes ☐ No Bladder spasms: ☐ Yes ☐ No Pain: ☐ Yes ☐ No
Urinary retention (as per bladder scanner): ☐ Yes ☐ No If yes, ____mL

If fecal: Sudden onset of incontinence: ☐ Yes ☐ No Explosive diarrhea: ☐ Yes ☐ No
Excessive flatus: ☐ Yes ☐ No Pain with bowel movement: ☐ Yes ☐ No

Quality of Life
Client/client's family satisfied with current continence management: ☐ Yes ☐ No

Sensory/Cognitive Perception
Aware of need to void: ☐ Yes ☐ No Aware of need for BM: ☐ Yes ☐ No
Cognitively able to follow care plan: ☐ Yes ☐ No

History Urinary Incontinence Episodes
☐ **Not available**

Frequency	Day:
	Night:
	Urgency: ☐ Yes ☐ No / With activity: ☐ Yes ☐ No If yes, which activities:
Volume	☐ Drips/spurts ☐ Small amounts ☐ Large amounts/gushing ☐ Continuous leaking

History Fecal Incontinence Episodes
☐ **Not available**

Frequency	Day:
	Night:
Volume	☐ Small amounts ☐ Large amounts ☐ Continuous leaking
Consistency	☐ Type 1: Hard lumps 
	☐ Type 2: Sausage-shaped, lumpy 
	☐ Type 3: Sausage-shaped, cracks 
	☐ Type 4: Sausage-shaped, smooth 
	☐ Type 5: Soft blobs with clear edges 
	☐ Type 6: Mushy with ragged edges 
	☐ Type 7: Watery 

Client's Current Management

☐ Toilet	☐ Pad/underwear	☐ Pull-up brief	☐ Catheter clamp
☐ Bedside commode	☐ Pad/mesh pant	☐ Tabbed brief	☐ Pessary
☐ Urinal	☐ Penile wrap	☐ Belted brief	☐ Penile clamp
☐ Bedpan	☐ External catheter		☐ Anal plug
Toileting Frequency_____	☐ External pouch		

Catheter/Intermittent: ☐ CIC/Self ☐ In&Out/Sterile Catheterization Frequency_____
Catheter/Indwelling: ☐ Urethral ☐ Suprapubic Catheter Change Frequency_____

Functional Concerns
☐ None ☐ Unable to manage clothing ☐ Limited mobility ☐ Poor hand dexterity

Environmental Concerns
☐ Not applicable ☐ Cluttered space ☐ Low toilet seat ☐ Other_____

Skin Assessment Peri-area/Buttock
Intact and healthy ☐ Yes ☐ No
Incontinence Associated Dermatitis (IAD) present: ☐ Mild ☐ Moderate ☐ Severe
If IAD present, length of time present, (e.g., x number of days)_____
Skin care products currently being used: _____

See Narrative Notes for Concerns ☐ **Date:** **Signature:**

Referrals

Continence Assessment by Continence Specialist (e.g., NCA, PT, Bladder Clinic, Urologist or Gynecologist)

Continence Clinic List

Done: ☐ Yes **Pending:** ☐ Yes If Yes:

By whom _____ Date:_____ Initials:____

If not done & client cognitively intact:

MRP contacted for referral ☐ Yes Date:_____ Initials:_____

Client not appropriate for referral ☐

Referral: Occupational Therapist: Date _____ Initials:_____

Referral: Pharmacist for medication review Date _____Initials:_____

Continence Containment Management Plan

Refer to care setting's specific Continence Containment Product Selection Guide to assist with developing the Management Plan

Daytime

Toileting:

Method: ☐ Toilet ☐ Commode ☐ Urinal ☐ Bedpan

Assistance: ☐ Independent ☐ One person ☐ Two person

Toileting Schedule: Urine_____ BM _____

External Devices:

☐ Condom/Size_____ ☐ Catheter ☐ Pouch

Pad/Wrap:

☐ Pad ☐ Liner ☐ Wrap Size_____

☐ Used with own underwear ☐ Mesh Pant/Size_____

Frequency of check/change: ☐ q2h ☐ q4h

Brief:

☐ Pull-up ☐ Tabbed ☐ Belted Size_____

Frequency of check/change: ☐ q2h ☐ q4h

Leave Open to Air: ☐ Yes Length of Time: _____

Other:_____

Nighttime

Toileting:

Method: ☐ Toilet ☐ Commode ☐ Urinal ☐ Bedpan

Assistance: ☐ Independent ☐ One person ☐ Two person

Toileting Schedule: Urine_____ BM _____

External Devices:

☐ Condom/Size_____ ☐ Catheter ☐ Pouch

Pad/Wrap:

☐ Pad ☐ Liner ☐ Wrap Size_____

☐ Used with own underwear ☐ Mesh Pant/Size_____

Frequency of check/change: ☐ q2h ☐ q4h

Brief:

☐ Pull-up ☐ Tabbed ☐ Belted Size_____

Frequency of check/change: ☐ q2h ☐ q4h

Leave Open to Air: ☐ Yes Length of Time: _____

Other:_____

Assess peri-area skin once a shift. For Incontinence Associated Dermatitis (IAD), assess if condition is improving or worsening. If worsening, inform Clinical Team Lead.

Adult Skin Care Protocol

☐ **Intact Skin** Do prevention steps <u>when providing peri-care</u> :

1. Gently cleanse peri-area with foam cleanser & warm damp wipe/cloth.

2. Apply a thin layer of skin protectant, (e.g., Remedy Protect) if pad/brief is used.

☐ **IAD* __Mild __Moderate __Severe** Do treatment steps <u>when providing peri-care.</u>

1. Gently cleanse peri-area with foam cleanser & warm damp wipe/cloth.

2. For areas covered with zinc protective cream, gently cleanse with foam cleanser to remove any soiled cream.

3. To protect & treat IAD areas and protect surrounding intact skin apply/reapply:

☐ Silicone protectant for Mild-Moderate IAD, (e.g., Remedy Protect).

☐ Zinc protective cream for Moderate-Severe IAD, (e.g., EPC).

4. To support healing, limit the use of briefs (pull-ups, belted or tabbed):

- Out of bed, consider an incontinent pad/penile wrap with mesh pants or external condom catheter.
- In bed, leave area open to air, consider external catheter, penile wrap, or disposable linen protector.

Additional Care:

Date: **Signature:**

*Use a checkmark to indicate the level of skin damage.