Continence Containment Assessment & Management Plan
Documentation Guide

This provincial document guides the documentation process; electronic health record or paper for the assessment of a patient, client or resident/person-in-care's continence status and if needed the management of any continence issues.

Type & Frequency of Assessment	
Care Setting	**Assessment**
Acute Care, Community & Long Term Care	• On admission to care. • Whenever there is a change in client's condition such as a deterioration of condition or an improvement in condition. • Prior to making a referral to an NCA, NSWOC and/or Continence Clinic for a continence issue. • Reassessment to be done in line with quarterly RAI assessment for LTC & Community Care.

*A **parameter** to be a 'question' used to ensure a comprehensive assessment.*

The table below lists the ***assessment findings*** *(terms used as an 'answer' for a parameter*) found on paper documentation form or within electronic health record. It lists both frequently used terms, as well as additional terms that may be found on the documentation form/screen which can also be used when the "Other' option is chosen.

- If a parameter is not needed for the assessment, document "Not Applicable"; (e.g., device insitu).
- If an assessment finding term is not listed, use 'Other' and add in the finding. If required by HA documentation processes, document 'Other' elsewhere in the client's chart, (e.g., narrative notes).
- Some HA/sites documentation systems may have less assessment finding terms available for selection, or there may be different terms available.

Assessment Findings for the Parameters	
Assessment Parameter *The 'question'.*	**Frequently Used Findings** **(Provincial Nursing Continence Committee standard)** *A possible 'answer' for the parameter.*
Continence Issue	Chose most appropriate answer: • Urine • Fecal • Both
Duration of Issue	Choose most appropriate answer: • Recent within last 3 weeks • Gradual • Sudden • Recurring • Longstanding Weeks/Months Years
If Urine	If 'urine' or 'both' was selected as the continence issue above then select Yes or No for the following: • Burning on voiding: ☐ Yes ☐ No • Bladder spasms: ☐ Yes ☐ No • Pain: ☐ Yes ☐ No • Urinary retention (as per bladder scanner): ☐ Yes ☐ No If yes, _____mL (enter volume of urine noted with scanner)

If Fecal	If 'fecal' or 'both' was selected as the continence issue above then select Yes or No for the following: • Sudden onset of incontinence: ☐ Yes ☐ No • Explosive diarrhea: ☐ Yes ☐ No • Excessive flatus: ☐ Yes ☐ No • Pain with bowel movement: ☐ Yes ☐ No
Quality of Life	Chose Yes or No: • Client/client's family satisfied with current continence management: ☐ Yes ☐ No
Sensory/Cognitive Perception	Select Yes or No for the following: • 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	If history not available, check off the 'Not Available' box.
Frequency	Day: enter free text.
	Night: enter free text.
	Urgency: chose Yes or No, If Yes, complete the following: With activity: chose Yes or No If Yes, list activities (free text).
Volume	Chose the most appropriate descriptor: • Drips/spurts • Small amounts • Large amounts/gushing • Continuous leaking
History Stool Incontinence Episodes	If history not available, check off the 'Not Available' box.
Frequency	Day: enter free text.
	Night: enter free text.
Volume	Chose the most appropriate descriptor: • Small amounts • Large amounts • Continuous leaking
Consistency	Chose the most appropriate descriptor: • 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	Chose the most appropriate answers: • Toilet • Bedside commode • Urinal • Bedpan For the four choices above indicate the Toileting Frequency_____ • Pad/underwear

	• Pad/mesh pant • Penile wrap • External catheter • External pouch • Pull-up brief • Tabbed brief • Belted brief • Catheter clamp • Pessary • Penile clamp • Anal plug
	For the following indicate the appropriate answer: Catheter/Intermittent: ☐ CIC/Self ☐ In&Out/Sterile Catheterization Frequency_____ Catheter/Indwelling: ☐ Urethral ☐ Suprapubic Catheter Change Frequency_____
Functional Concerns	Chose the most appropriate answer: None • Unable to manage clothing • Limited mobility • Poor hand dexterity
Environmental Concerns	Chose the most appropriate answer: • Not applicable • Cluttered space • Low toilet seat • Other_____ (write free text)

Skin Assessment Peri-area/Buttocks	Indicate most appropriate answer:
	• 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) - write in free text
	• Skin care products currently being used: write in free text

Documentation	See Narrative Notes for Concerns ☐ Check if concerns noted Date: Free text Signature: Free text name and designation

Referrals	Check of the most appropriate answer:
	Continence Assessment by Continence Specialist
	• Done: ☐ Yes
	• Pending: ☐ Yes
	  ○ If Yes: By whom (write in free text)
	  ○ Date: (free text)
	  ○ Initials: (free text)
	• If not done & client cognitively intact:
	  ○ MRP contacted for referral ☐ Yes (check mark)
	  ○ Date: (write in free text)
	  ○ Initials (write in free text
	• Client not appropriate for referral ☐ Check mark if appropriate.

	If done: • Referral: Occupational Therapist: ○ Date: write in free text) ○ Initials: (write in free text) • Referral: Pharmacist for medication review: ○ Date: write in free text) ○ Initials: (write in free text)

Continence Containment Management Plan	
Enter a check mark for those continence containment strategies and devices to be used during the day: **Toileting**: • Method: ○ Toilet ○ Commode ○ Urinal ○ Bedpan • Assistance: • Independent • One person • Two person Indicate when toileting should be done, (e.g., q3h for voiding, 09:00 for BM): Toileting Schedule: Urine_____ BM _____ **External Devices:** • Condom/Size_____ (write in free text) • Catheter • Pouch **Pad/Wrap:** • Pad • Liner • Wrap If pad or liner chosen: Size_____ write in free text • Used with own underwear • Mesh Pant/Size___ (write in free text Indicate how often pad, liner, wrap is to be changed: • Frequency of check/change: □ q2h □ q4h **Brief:** • Pull-up • Tabbed • Belted • Size_____ (write in free text) Indicate how often brief is to be changed: • Frequency of check/change: □ q2h □ q4h Leave Open to Air: • Yes. If Yes, enter length of time (write in free text Other: write in free text	Enter a check mark for those continence containment strategies and devices to be used during the day: **Toileting**: • Method: ○ Toilet ○ Commode ○ Urinal ○ Bedpan • Assistance: • Independent • One person • Two person Indicate when toileting should be done, (e.g., q3h for voiding, 09:00 for BM): Toileting Schedule: Urine_____ BM _____ **External Devices:** • Condom/Size_____ (write in free text) • Catheter • Pouch **Pad/Wrap:** • Pad • Liner • Wrap If pad or liner chosen: Size_____ write in free text • Used with own underwear • Mesh Pant/Size___ (write in free text Indicate how often pad, liner, wrap is to be changed: • Frequency of check/change: □ q2h □ q4h **Brief:** • Pull-up • Tabbed • Belted • Size_____ (write in free text) Indicate how often brief is to be changed: • Frequency of check/change: □ q2h □ q4h Leave Open to Air: • Yes. If Yes, enter length of time (write in free text Other: write in free text

Management Plan
Check the box for **Intact Skin** to indicate care is to be done.

Check the box for **IAD** if noted.
• Indicate if IAD is
  ○ Mild
  ○ Moderate
  ○ Severe
Check box for which treatment is to be used:
• Silicone protectant
Zinc protective cream

Additional Care: write in free text.
Documentation • Date: write in free text • Signature: write in free text name & designation