

NHS GRAMPIAN

GUIDELINES and INFORMATION

ON COMPLETION

OF

ASSESSMENT FORM – CODE NUMBER ZOY890

**Continence Advisory Service – Inverurie Hospital
NHS Grampian**

**August 2010
Date of review August 2012**

**Continence Resource Pack – 2008
Section Two
Item – D**

GUIDELINES TO COMPLETION OF CONTINENCE ASSESSMENT FORM

The **AIM** of guidelines is that all patients in NHS Grampian with continence problems are assessed and treated on an individual basis according to the Charter for Incontinence. NHS Quality Improvement Scotland Document Continence www.nhshealthquality.org adults with urinary dysfunction.

AIMS OF CARE

- To promote continence
- To reduce the incidence of incontinence
- To reduce the severity of symptoms

INTRODUCTION TO ASSESSMENT

The purpose of the assessment is to help identify the many different causes and contributing factors resulting in urinary and faecal symptoms.

In the majority of cases these symptoms can be improved or cured by identifying and treating the underlying causes. From a full assessment treatment/management of the patients' problem can be implemented.

NOTES ON COMPLETION OF ASSESSMENT FORM

- The patient/client must be assessed by a trained nurse using the **Continence Assessment Form** and **Guidelines and Information on Completion of Assessment Form**
- Please tick (✓) the appropriate boxes and add any comments as necessary. If you or the patient/client or carer are unable to answer any of the questions please indicate this on the Continence Assessment Form. **DO NOT LEAVE ANY SECTION UNANSWERED** e.g. if a patient has normal mobility, document – no problems.
- Please sign the Continence Assessment Form.
- When the assessment form is completed a promotion of continence plan should be implemented.
- The questions contained under the headings in the following pages are only suggestions and is not an exhaustive list.

SECTION ONE - PATIENT DETAILS

<u>Name</u> –	The client's full name should be recorded
<u>Address and Postcode</u> –	Should be completed in full
<u>D.O.B./Unit/CHI Number</u> –	Enter Unit or CHI number if known
<u>Occupation</u> –	What is their current job?
<u>Hobbies/Activities</u> –	Do they play golf, do aerobics, walk?
<u>G.P./Address/Tel Number</u> –	Is essential for referral to Hospital etc
<u>Date of Referral</u> –	Who referred this patient to you and when?
<u>Name of Health Care Professional</u> –	Professional completing form
<u>Date Assessment Commenced</u> –	
<u>Location of Assessment</u> –	Could be Patient's Home, Hospital, Nursing Home

SECTION TWO - FACTORS AFFECTING INDIVIDUALS ABILITY TO COPE

A. MSQ SCORE

- Using the MSQ (Mental Status see **APPENDIX ONE**) questions please record the patients score in the space provided. Each correct answer scores one point
- A low score may result in poor compliance with treatment.

B. PLEASE RECORD THE PATIENT HOME CIRCUMSTANCES

- This will give a full picture of the patient's home circumstances. This information will be important in treatment implementation.

C. COMMUNICATION

- **SPEECH** (clients who have speech problems may have difficulty in making their needs known)
Does the patient have any speech difficulties?
Does the patient have swallowing difficulties?
Does the patient have dentures – do they fit properly?
- **SIGHT** (a client with impaired sight can have difficulty finding and using a toilet)
Can the patient see to access the toilet?
Does the patient wear spectacles?
Does the patient have problems with their visual fields – when did they last have an opticians assessment?
- **HEARING** (if a patient has a hearing loss information may be misunderstood)
Is the patient hard of hearing?
Is the patient deaf?
Does the patient wear a hearing aid?

- D. **MANUAL DEXTERITY** (the client needs to be able to co-ordinate fine finger movements in order to dress and undress).
Can the patient hold their cutlery/cup/glass?
Can the patient dress/undress themselves?
Can the patient undo zips/buttons/fastenings?
- E. **MOBILITY** (this can be an important factor in maintaining continence)
Is the patient independent?
Can the patient get out of the chair/bed unaided?
Does the patient use a walking aid/wheelchair?
Does the patient require to use a hoist?
- F. **USING THE TOILET** (may indicate need for aids)
Is the patient able to access the toilet/commode unaided?
Can the patient get to the toilet in time?
Can the patient get on/off the toilet unassisted and clean him or herself?
Are the patient's feet supported whilst on the toilet?
Would the patient benefit from an O.T./Physiotherapy assessment?
- G. **OTHER AGENCIES INVOLVED**
Do they have - Care Manager, Home Care, Community Psychiatric Nurse Support Worker or Private Agency input?

SECTION THREE - PAST MEDICAL HISTORY

- This section is made up of a series of boxes to tick (✓) in order to detail medical, surgical or obstetric conditions. Record date illness commenced.
- These may affect the client's ability to maintain continence or contribute to urinary/faecal incontinence.
- For further information on these conditions details can be obtained from e.g. Library, Internet, Intranet and liaison with other Health Care Professionals
- Also is there any depression that may lead to denial of problem and poor motivation.
- Obstetric history – How many children, weight of babies, length of labour, forceps delivery.
- **Computer patient summary printouts from the G.P. Practice can be attached if available to the Continence Assessment Form.**

SECTION FOUR – MEDICATION

- See **APPENDIX TWO** for Medication which can contribute to Urinary Incontinence
- Refer to B.N.F./Intranet/Grampian Drug Formulary/Pharmacist for more detailed information.
- Has their drug regime been recently reviewed?
- Record side-effects of medication, which relate to bladder/bowel dysfunction.
- **Drug summary printouts if available can be attached to Assessment Form**

SECTION FIVE – ALLERGIES

Please document any known allergies/sensitivities or known anaphylactic reaction e.g.

- Latex
- Lanolin
- Peanut allergy (arachis oil enema)

SECTION SIX - PRESENTING SYMPTOMS

- Please document, as this will indicate how the patient's quality of life has been affected and will determine the motivation of patient and possible outcome of treatment
- Has it been related to an event e.g. surgery, urinary infection, illness
- Has it stopped them going to the shops, clubs, playing golf etc?

SECTION SEVEN- URINARY SYMPTOMS

- Ask the patient to tell you if they present with any of the following and tick any that apply:-

FREQUENCY OF URINE

- Average number of voids in 24 hours is 6-8 voids
- Maximum functional bladder capacity is 400-600ml, this can reduce with age
- How often does the patient go to the toilet during the day and night?
- This may also vary with fluid intake

URGENCY – Have a strong desire to pass urine

- Does anything trigger the feeling of needing to go e.g. running water, key in door?
- Can the patient hold on after feeling the need to go to the toilet?
- Have they a sudden feeling of needing to go?

STRESS INCONTINENCE – complaint of involuntary leakage of urine on effort or exertion or on sneezing or coughing

SIGNS

- Does the patient leak a little on laughing, sneezing, coughing, lifting or on sudden movement?
- Is there warning of needing to go?
- Is toileting otherwise normal?

URGE INCONTINENCE – Complaint of involuntary leakage accompanied by or immediately preceded by urgency.

SIGNS

- Frequency
- Urgency
- Nocturia
- Urinary incontinence – variable amounts
- Wakening with a need to void
- Little or no warning
- Be able to hold on until a toilet is reached
- Wet before the toilet is reached
- Moderate/large amounts of urine passed

DETRUSOR OVERACTIVITY INCONTINENCE – in the past known as **REFLEX INCONTINENCE** – Is incontinence due to an involuntary detrusor contraction.

SIGNS

- Incomplete bladder emptying
- Urgency
- Frequency
- Nocturia
- Urinary Tract Infection's
- Wets themselves without feeling the need to pass urine

DYSURIA – Pain on passing urine

- This may indicate a Urinary Tract Infection.
- Is there pain before, during or after voiding?

HAEMATURIA - Blood in the urine

- The urine may also be discoloured due to drugs or food
- Prolonged haematuria needs to be investigated further
- May indicate UTI

RELATED TO SEXUAL INTERCOURSE

- Leakage of urine during or after sexual intercourse. This may precipitate bladder contraction resulting in incontinence
- Refer to R.C.N. Guidelines – Sexuality and Sexual Health in Nursing Practice

HESITANCY – Delay in starting flow of urine

POOR STREAM – Slow or intermittent flow of urine

STRAINING

- Does the patient have to press on abdomen or change position to pass urine?

POST MICTURITION DRIBBLE – Loss of urine following completion of voiding

If symptoms of hesitancy, poor stream, straining, post micturition dribble are present a post micturition residual volume should be obtained as it may indicate

- Incomplete bladder emptying
- Voiding difficulties

DUE TO

- Hypotonic bladder
- Medication
- Constipation
- Urethral stricture
- Anaesthetic

AWARENESS OF LEAKAGE

- Does the patient know when they are passing urine or are wet?
- Are they aware that a dribble/leak is occurring even though they cannot stop it?

NOCTURIA – Number of voids recorded during a night's sleep, each void preceded and followed by sleep. Up to pass urine at night, the patient is woken by sensation of full bladder

- Normal, due to ageing process, 1-2 times per night
- How often does it happen?

NOCTURNAL ENURESIS

- Does the patient wet the bed while asleep, waking to pass urine? May indicate residual urine
- Does the patient waken needing to go to the toilet, but is unable to get to the toilet in time? May indicate unstable bladder
- Does the patient waken needing to go to the toilet, but cannot get there due to reduced mobility

OTHER

Please indicate any other symptoms/signs, the patient's experiences e.g.

- Recurrent UTI'S
- Thrush infection

SECTION EIGHT - DEGREE OF INCONTINENCE

- Please indicate the degree of wetness the patient experiences.
- If the patient uses pads e.g. sanitary pads please document what type, and if they contain any leakage of urine.

SECTION NINE - INFORMATION FROM FREQUENCY VOLUME CHART

This is an essential part of the client's assessment. The information gained from this chart in conjunction with the written assessment will help you to identify the underlying causes and tell you about the extent of the problem

Patterns of voiding can point towards: -

- Stress, urge, incomplete bladder emptying (Overflow) or Detrusor Overactivity Incontinence (Reflex)
- Detrusor instability, obstruction, atrophy, side effect of medication
- Reduced fluid intake, below 1500mls in 24 hours
- Increased fluid intake above 2000mls in 24 hours

Bladder capacity

Min - smallest volume of urine recorded on the chart

Max - largest volume of urine recorded on the chart

Number of voids

Min - least number of times the client has passed urine in 24 hours

Max - most number of times the client has passed urine in 24 hours

Interval between toileting

Min - shortest time between each visit to the toilet

Max - longest time between each visit to the toilet

Frequency of toileting

Min - least number of incontinent episodes within a 24 hour period

Max - most number of incontinent episodes in a 24 hour period

Nocturia

Min - least number of times urine is passed after bedtime

Max - most number of times urine is passed after bedtime

Fluid intake

Min - smallest amount of fluid drunk within a 24 hour period

Max - largest amount of fluid drunk within a 24 hour period

SECTION TEN – FOOD INTAKE AND APPETITE

The patient's inability to feed may lead to an inadequate fibre or fluid intake, which may then lead to constipation, confusion or urinary incontinence

- Average fluid intake 1800 - 2000mls
- Do they have an excessive fluid intake over 2000mls, this may cause frequency.
- Does the patient have a high caffeine intake e.g. coffee, coke, iron-bru?
- Do they drink during the night and if so what?
- Do they consume alcohol and if so what quantity?
- Is the diet adequate?

- Is there enough fibre in the diet? If not consider referral to Dietician for further assessment
- Is eating pattern regular during the day?
- Is the patient on Peg feeding (gastrostomy)? (this will increase the urinary output)

SECTION ELEVEN - EXAMINATION AND INVESTIGATION

1. **Remember to gain informed consent from the patient before undertaking any procedure. Provide the reason on why it is necessary. Refer to NHS Grampian Informed Consent Policy.**
2. **If the patient/client requires to be referred to a G.P./DR then provide an explanation or provide literature on tests to be performed.**
3. **Patient should be offered the opportunity to have a chaperone present during the examination.**

PHYSICAL EXAMINATION

A. SKIN PROBLEMS – check for

Female

- Vaginal Atrophy – fall in oestrogen levels after the Menopause/Hysterectomy. Vagina may appear red, inflamed and dry. Symptoms may also include frequency, urgency and pain on intercourse. Patients may benefit from oestrogen therapy.
- Fungal infection
- Vaginal discharge
- Skin soreness may be due to -
 - Wet clothing
 - Wearing inappropriate or poor fitting pads
 - Excessive use of toiletries e.g. bubble bath

Male

- Phimosis (narrowing of opening of foreskin which cannot be drawn back over the penis)
- Penile discharge?
- Fungal infection?
- Skin soreness around scrotal area may be due to -
 - Badly fitting collection device
 - Wet clothing
 - Wearing inappropriate or poor fitting pads

OBVIOUS PROLAPSE

- Is a prolapse evident?
- Does the patient complain of something coming down, dragging sensation or back pain?
- Refer to G.P. to exclude prolapse if any of these symptoms apply

ABDOMINAL PALPATION - To exclude palpable bladder or constipation.

- Incontinence could be a result of incomplete emptying of bladder due to obstruction or atonic bladder

POST VOID RESIDUAL

- A bladder scan or residual catheterisation should be performed to obtain an accurate urine measurement if there is any indication of voiding problems.

RECTAL EXAMINATION

- To exclude faecal impaction if constipation is suspected
- To assess prostate gland size this should be performed by G.P./Dr
- Refer to RCN Document on Digital Rectal Examination and Manual Removal of Faeces (2008)

PELVIC FLOOR STRENGTH

This should only be performed if further training has been undertaken or by referral to physiotherapist.

Examination will help to assess the strength of the pelvic floor muscle so an individual programme of pelvic floor exercises can be initiated.

B. URINALYSIS

Urine - which has been in the bladder for four hours or an early morning specimen, will give the most reliable results
Write down any abnormalities and report to G.P.

Glucose - May indicate diabetes mellitus. Associated urinary symptoms of frequency and urgency may lead to incontinence.

Specific Gravity - If it is low may indicate diabetes insipidus, if high dehydration from vomiting, diarrhoea or strenuous exercise.

pH - This is the measure of hydrogen ion concentration.
Normal range 4.5-8.0. Acidic urine (below 4) may be associated with starvation, diabetes mellitus or respiratory disease. Alkaline urine (above 8) may be associated with prolonged vomiting, or vegetarian diet. Calculi can be formed in alkaline urine, therefore if a patient is prone to kidney stone formation it may be helpful to maintain acidic urine.

Blood - Haematuria results from bleeding into renal system. Possible causes, kidney damage due to trauma, glomerulonephritis, pyelonephritis, strenuous activity, cystitis, calculi, tumours and urinary tract infections (For further information refer to SIGN 17 and 18 Guidelines).
Is the female patient menstruating?

Ketones - These are produced as a result of fat metabolism; causes can be vomiting, starvation and diabetes mellitus.

Leukocytes - Usually associated with inflammation of the urinary tract e.g. cystitis, urethritis. Contamination from vaginal secretions will give a false reading.

<u>Protein</u> -	May indicate a urinary tract infection Screening for renal disease (Refer to SIGN 17 and 18 Guidelines)
<u>Nitrate</u> -	May indicate a urinary tract infection

C. MSSU

Please insert the date and results from any MSSU sent

SECTION TWELVE - BOWEL

COMPLETE BOWEL ASSESSMENT FORM IF COMPLEX PROBLEMS

BOWEL CHART – ZOY892

3 DAY FOOD AND FLUID CHART – ZOY893

BOWEL ASSESSMENT FORM – ZOY894

- **Stool consistency**
Refer to the Bristol Stool Chart in – (**APPENDIX THREE**)
- **Recent changes** –
 - Is there an identifiable cause for this?
 - Change in toilet facilities e.g. bedpan, raised toilet seat or commode
 - Change in diet
 - Change in home circumstances
 - Change in medication
- **Constipation** - (may cause urinary incontinence by compression on the bladder or urethra)
 - Does the patient use laxative to resolve this?
 - Has the patient been commenced recently on aperients/analgesia?
SEE APPENDIX FOUR FOR DRUGS THAT CAN CAUSE CONSTIPATION
 - History of straining at stool
- **Diarrhoea**
 - Is the patient on an antibiotic?
 - Is patient on high protein supplement that may cause this?
 - Medical condition e.g. Bowel Cancer, Crohns Disease
- **Is there any stool colour change?**
 - Melena?
 - Clay colour?
- **Is there any associated bleeding?**
 - Has the patient haemorrhoids?
 - Anal fissure?
 - Refer to G.P. if any unexplained bleeding

- **Smearing and Frequency**
 - Patient's inability to clean themselves sufficiently following bowel movement
- **Faecal Incontinence**
 - Fluid soiling with no solid matter may indicate severe constipation
- **Is the patient aware of faecal incontinence** – may indicate
 - Lack of sensation may indicate lack of anal sphincter tone
 - Neurological damage?
 - Trauma from childbirth

SECTION THIRTEEN – PROBLEMS IDENTIFIED FROM ASSESSMENT

Please record information on main problems identified from assessment e.g.

- | | |
|-----------------------------|-------------------------|
| • Poor oral intake | • Poor mobility |
| • Constipation | • Poor eyesight |
| • Side-effect of medication | • Unaware of being wet |
| • U.T.I. | • Provisional diagnosis |

SECTION FOURTEEN – PROMOTION PLAN

Information on this is also available from

- Link Nurse Resource Pack
- Pelvic Floor Exercise Sheet – Code Number ZOF 931
- Catheter Information Booklet – Code Number ZML 998
- How to Keep Your Bladder Healthy – Code Number ZML 700
- **SEE APPENDIX FIVE FOR SIMPLE INSTRUCTIONS TO AID CONTINENCE**
- Continence Advisors.
Inverurie Hospital – 01467 672748 ext 72748
Woodend Hospital – 01224 556235
Spynie Hospital – 01343 567145
Urology Nurse Specialist, ARI - Extn 52766
Urology Nurse Practitioner, Dr Gray's – Extn 67384
Ward 10, Dr Gray's – Extn 67282

SECTION FIFTEEN – MANAGEMENT PLAN

- Please record the information of selected product, size, and daily amount, code numbers. These may change so will require to be updated
- Information is also available from the Link Nurse Continence Resource Pack.

Commode

- Refer to Local Policies for Community Staff

Urinal

- Available from Central Stores
- Available to buy
- Small selection available on prescription, further information available in Scottish Tariff

Sheaths

- Use manufacturers guide for measuring and follow instructions

Washable Pants

- Ensure patient is measured for the correct size and absorbency of product
- Ensure patient/carer can launder the product (read instructions and provide information sheet to patient)
- Do not use fabric conditioner
- 6 pairs issued over 1 year, ordered via the Continence Service
- Initially order 2 or 3 pairs to ensure patient compliance, proper fit and correct absorbency

Pads

- Refer to Frequency Volume Chart for correct product

Stretch Fit Pants

- To be worn with Pad size 6, 7, 8 – 3 pairs issued every 12 weeks
- Patient should be encouraged to wear their own close fitting underwear with rectangular products, Soft 4 and Soft 5
- These can be worn with F6, C6, C7 and C8

Washable Bed Sheet

- Authorisation to be given by Continence Advisor
- Sahara Bedpad Request Form – this is included in your Resource Pack

I.S.C. (Intermittent Self Catheterisation)

- Single use lubricated catheters should be used
- For further information contact Continence Advisors

Indwelling Urinary Catheter

- State catheter type e.g. hydrogel, silicone
- Size and length of catheter
- **Record details of catheterisation on CATHETER Record Sheet – ZML 997**
- **Record details of catheter maintenance solution on catheter maintenance sheet – ZML 996**
- **Catheter Care Booklet – ZML 998**
- **Refer to Urinary Catheterisation Catheter Care Guidelines 2006**

Leg Bag/Catheter Accessories

- State manufacturer type, length of tubing, size of bag
- Statlock/cliniflex and catheter sleeves can also be used
- Further information on these can be obtained from the Scottish tariff

Night Bag

- State manufacturer and type of bag

Catheter Valve

- Refer to section 5 in the Scottish Drug Tariff for indications
- Refer to Urinary Catheterisation and Catheter Care Guidelines 2006

Enuretic Alarm

- Mainly used for children
- If further information required please contact Continence Advisor

APPENDIX INDEX

APPENDIX ONE - MENTAL STATUS SCORE (MSQ)

APPENDIX TWO - MEDICATION WHICH CAN CONTRIBUTE TO
URINARY CONTINENCE

APPENDIX THREE - BRISTOL STOOL CHART

APPENDIX FOUR - DRUGS THAT CAN CAUSE CONSTIPATION

APPENDIX FIVE - SIMPLE INSTRUCTIONS TO AID CONTINENCE

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SIGN 17 – Investigation of Asymptomatic Proteinuria in Adults

SIGN 18 – Investigation of Microscopic Haematuria in Adults

SIGN 79 – Management of Urinary Incontinence in Primary Care – December 2004

SIGN 88 – Management of Suspected Bacterial Urinary Tract Infection in Adults – July 2006

APPENDIX ONE

MENTAL STATUS QUESTIONNAIRE (MSQ)

ASK THE PATIENT/CLIENT THE FOLLOWING QUESTIONS

1. What is the name of this place?
2. Where is it located (address)?
3. What is today's date?
4. What is the month now?
5. What is the year?
6. How old are you?
7. When were you born (month)?
8. When were you born (year)?
9. Who is the Prime Minister of the United Kingdom?
10. Who was the Prime Minister before him?

APPENDIX TWO

Medication Which Can Contribute to Urinary Incontinence

<u>MEDICATION</u>	<u>MECHANISM</u>	<u>SIGNS/SYMPTOMS</u>
Anticholinergics (Psychotropics, antidepressants, antispasmodics, Atropine, Hyoscine, Propantheline, Anti-Parkinson Drugs).	Detrusor muscle relaxation.	Hesitancy, straining to void, Retention with overflow incontinence.
Diuretics: Thiazide & loop diuretics	Diuresis (increased urine volume).	Frequency, urgency, urge incontinence if immobile.
Psychotropics (anti-psychotics Chlorpromazine, Thioridazine, tricyclic antidepressants: Amitriptyline, Imipramine sedative/hypnotics, anxiolytics	Sedation making the person less receptive to messages from the bladder about the need to void; anticholinergics detrusor relaxation.	Hesitancy, straining to void, retention with overflow incontinence.
Alpha-adrenergic blockers Doxazosin, Prazosin, Terazosin	Decreased urethral resistance, sphincter relaxation.	Stress incontinence, Urinary frequency.
Calcium channel blockers: <u>Nifedipine, Lacidipine</u>	Detrusor relaxation increased residual volume.	Polyuria, frequency.
Alcohol	Diuresis, sedation	Urge incontinence/ Nocturnal enuresis
Muscle relaxants: Baclofen, Dantrolene, Diazepam	Urethral sphincter relaxation	Polyuria, frequency, urgency
Caffeine	Diuresis, aggravates detrusor instability	Frequency, urgency, urge incontinence

Drugs can occasionally precipitate incontinence either as a direct result of their therapeutic action or as a side effect.

APPENDIX FOUR

DRUGS THAT CAN CAUSE CONSTIPATION

- Analgesia Drugs - e.g. M.S.T., Co-proxamol
- Antacids - e.g. Aluminum Hydroxide (Maalox)
- Anticholinergics - e.g. Oxybutynin
- Antidepressants - e.g. Lithium
- Antihypertensives - e.g. Calcium Channel Blockers
- Antiarrhythmic - e.g. Verapamil
- Metals - e.g. Iron
- Sympathomimetic - e.g. Dopamine, Adrenaline

APPENDIX 5

SIMPLE INSTRUCTIONS TO AID CONTINENCE

DECREASE CAFFEINE

WHY? Caffeine can act as a stimulant to the bladder. An excess can cause, or increase urgency, and reduce the time between first feeling the desire to pass water, and it becoming a matter of urgency to reach the toilet.

HOW? Caffeine is contained in many drinks, especially tea, coffee, cola and various other soft drinks. Patients should be advised to switch to decaffeinated tea or coffee and to choose soft drinks, which do not contain caffeine such as flavoured waters or fruit squashes. The best drink, and the cheapest, is plain water.
It is advisable to slowly reduce caffeine intake.

STOP DRINKING AFTER 7.00P.M. :

WHY? Some people are troubled by having to get up to the toilet several times during the night. It is not a problem for everyone, but if you cannot get back to sleep and are still tired and not rested by the morning it needs to be sorted.

HOW? If you stop drinking earlier in the evening, by the time you go to bed most of what have drunk during the day will have passed through your system, and your bladder will not fill up so frequently during the night. If your bladder is not full you are less likely to waken and your sleep will not be so disturbed.

GO TO THE TOILET EVERY 3 HOURS, EVEN IF YOU DON'T FEEL YOU NEED TO:

WHY? Some people have *reduced bladder sensation* meaning they do not feel when their bladder is full (or nearly full) and get little warning of the need to go to the toilet.

HOW? If you empty your bladder every 2-3 hours it will not become overfull and you will not need to rush to the toilet. Completing a frequency volume chart will tell you how long to leave between visits to the toilet.

DOUBLE VOID WHEN YOU GO TO THE TOILET:

WHY? Double voiding allows you to empty your bladder more efficiently. If your bladder is completely empty it will take longer to fill up again.

HOW? When you pass water wait until you have finished and then either stand up, sit down again, and try again *or* in the case of gentlemen, or those who have difficulty in getting up and down, when you think you have finished – wait a few minutes, then try to pass water again. In most cases only small amounts will be passed, but sometimes it will be a considerable amount.

ELEVATE LEGS:

WHY?

Fluid can accumulate in the tissues during the day, especially if the patient has a circulation problem. When the patient goes to bed this fluid is returned to the circulatory system and urine is produced. This can mean the patient having to rise several times during the night to pass water.

HOW?

It is important to lie down, rather than just sit with the legs on a stool. This will increase cardiac function and thus improve flow to the kidneys, increasing urine production. If this is done in the afternoon there will be less fluid accumulated at night, and therefore less sleep disturbance.

AVOID CONSTIPATION:

WHY?

A loaded bowel can cause pressure on the urethra (the tube which urine flows through from the bladder). This can make it difficult to pass urine and it may mean the bladder is ***not*** empty when the patient thinks they have emptied their bladder.

HOW?

Eat a healthy diet with plenty of fruit and vegetables. Drink about 8 cups or glasses of fluid a day. Try to take plenty of exercise. Ask your doctor or nurse for advice or help if this is not working for you.