

## Bristol Community Health Bladder and Bowel Service Assessment Form

<b>Community Nursing/HCP</b>	<input type="checkbox"/>
<b>Residential Care Home</b>	<input type="checkbox"/>
<b>Nursing Care Home</b>	<input type="checkbox"/>

Please tick 1 box

Date of Assessment:
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Patients Name:	Date of birth:
NHS Number:	Male/ Female/ Prefer not to say (please circle)
Address (including postcode):	GP: GP Surgery:
Mobile Telephone Number:	
Telephone Number:	
Email:	

Patient's and/or Carer's aims and goals for treatment:	
How much does the problem bother you? 0 (Not Bothersome)- 10 (Extremely Bothersome):	
Shared Decision Making:	
1. Which of your patient's needs, concerns or wishes did you discuss today?	2. Any agreed outcomes from the above discussion?

<b>Palliative patient</b>	<b>YES</b>	<b>NO</b>
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<p>If the patient is <b>palliative</b> please use the <b><i>Process for Managing Palliative Patients</i></b> document and give an appropriate priority score. Liaise with Bladder and Bowel team on 0117 3737118 as soon as possible.</p> <p><b>Palliative Priority Score:</b></p>
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Patient name..... D.O.B..... NHS Number: .....

**Please complete all sections. NOTE** if a Healthcare Assistant/Assistant Nurse Practitioner completed the form then a Registered Nurse **MUST** countersign.

<b>1. Presenting Bladder / Bowel Problem</b> (Include details & complete: 4 Day Bladder Diary & Bladder Symptom Profile and/or 14 Bowel Diary & Bowel Symptom Profile)	
Urinary:	Faecal:
Date of onset of problem:	Was onset related to anything?

<b>2. Symptoms</b>		
Number of episodes of leakage?..... <b>Per day / week</b> (Please circle)	Amount of urine leaked? (Please circle) <b>Light Moderate Heavy</b>	Amount of faeces leaked? (Please circle) <b>Light Moderate Heavy</b>

<b>3. Continence Products/ Management</b>	
Is Pad used for incontinence?	<b>YES / NO</b>
Type:	
Amount:	
Products: eg. sheath	

<b>4. Relevant Health History</b>			
Current weight:			
No Known Medical History:	Mental/ cognitive ability	Impaired	<input type="checkbox"/>
		Unimpaired	<input type="checkbox"/>
Stroke (CVA)/ Cardio Vascular Disease:	Spinal Injury:		
Parkinson Disease:	Diabetes:		
Hysterectomy:	Cancer:		
Prostatectomy:	Mental Health Problems:		
Multiple Sclerosis:	Smoker:		
Bladder/ Bowel Surgery:	Neurological Condition:		
Other relevant health history:			
Coeliac / Irritable Bowel Syndrome / Lactose intolerance			
Obstetric History: (If Applicable)			
Number of Pregnancies:	Forceps Deliveries <b>Yes / No</b>	Number of large babies (over 9lbs/4kg):	Number of difficult births/long deliveries:
Investigations for current Problem:			

**Allergies/ Intolerance:** None Known

Yes (Medications/ other substances including food):

**Medication:** Prescribed and over the counter (especially St John's Wort- can affect other medications)

### 5. Diets and Fluids

Types of Fluids: Including Alcohol

Average fluid Intake over 24 hours:

Number of drinks?:

Mixed balanced diet? (Including Fibre):

Food Avoided:

Food that helps your Bowel:

### 6. Bowel Habit

Bowel Habit: (Please circle)      **Daily**      **Multiple Times**      **Less Often**

Stool Type/ Consistency:      **Normal**      **Constipated**      **Diarrhoea**

Bristol Stool Type:

(Please refer to the Bristol Stool Chart for definition)

Faecal Incontinence?

Have you noticed any? (RED FLAGS):

**Bleeding   Mucous   Increased Flatus   Unexplained Weight loss   Change in bowel habit**

**If patient in obvious distress due to gaping anus with loaded rectum. Consider immediate intervention.**

If acute diarrhoea consider sample to GP if suspect infective diarrhoea.

Laxatives: Name/ Dose

Colour of Stool:

Does patient have any warning before they have bowel movement?

How long can the patient hold on for?

Does the patient get any sensation of: **Hard stool   Soft stool   Wind   No sensation**

Patient name..... D.O.B..... NHS Number: .....

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<b>7. Mobility</b>		
Fully Mobile	<input type="checkbox"/>	Toilet Facilities: <b>Upstairs Downstairs Commode?</b> Special Equipment? <b>Falls history:</b> In last year? (for referral to falls clinic)
Uses Aid	<input type="checkbox"/>	
Chairbound	<input type="checkbox"/>	
Can get on and off the toilet?	<input type="checkbox"/>	
Aid and Carer?	<input type="checkbox"/>	

<b>8. Dexterity</b>		
Fine finger movements good?		
Manages clothing quickly and easily?		
Personal Hygiene after toileting:	<b>Independent</b>	<b>Needs assistance</b>
		<b>Dependant</b>

<b>Social (Not applicable if in Nursing/ Residential Home)</b>	
Package of care	Details:
Lives alone?	

**SECTION BELOW TO BE COMPLETED BY COMMUNITY NURSES AND NURSING HOMES ONLY**

Urinalysis	<b>Results:</b> If leucocytes & nitrites present or symptoms of UTI, send GP surgery a clean catch of urine specimen. <b>Suspend assessment until treatment is complete refer to BSSNG UTI guidance</b>  MSU Sent? <b>YES NO</b>
Vaginal Examination	Full valid verbal consent for vulva examination <b>YES NO</b> Vaginal Mucosa: (Please circle) <b>Healthy / Skin Disorder:</b> Prolapse: <b>YES NO</b> details:
Skin	Full valid verbal consent for penile examination <b>YES NO</b> Outcome:
Bladder Scan:	Bladder scan completed: <b>YES NO</b> Post Void Residual Amount: ..... ml: Outcome:
Catheters	Does patient have long term catheter or perform Clean Intermittent Self Catheterisation? <b>YES NO</b> If YES, Size and Brand:

Rectal examination	Full valid verbal consent for Rectal Examination obtained: <b>YES NO</b>  DRE: Outcome:	Indications: Constipation, Voiding Difficulties, Urge Incontinence and Passive Incontinence. Please see bowel care pathway for details.
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Patient name..... D.O.B..... NHS Number: .....

**ASSESSMENT MUST BE SIGNED** (BY A REGISTERED NURSE IF FROM COMMUNITY NURSES OR NURSING HOME)

Signature of Assessor:

Date:







Print Name:

Base:

**REQUISITION FORM FOR CONTINENCE PRODUCTS  
FOR COMMUNITY NURSE USE ONLY**

**1. Samples trialled? YES / NO**

Please note if samples have not been trialled the assessment will be rejected and returned.

2. Please select product & write number of pads per day (NB no more than 3 products per 24 hrs can be authorised)	No of pads	Working Capacity	Uses and fitting
 <input type="checkbox"/> Strampelpeter 1	.....	147ml	<ul style="list-style-type: none"> <li>For faecal smearing/incont.</li> <li>No waterproof back sheet</li> </ul>
 <input type="checkbox"/> MoliNea Couche 3	.....	241ml	<ul style="list-style-type: none"> <li>For slight urinary / faecal incont.</li> <li>Adhesive strip</li> <li>Use within close-fitting underwear</li> </ul>
 <input type="checkbox"/> MoliNea Plus 20x40cm <input type="checkbox"/> MoliNea Plus 20x60cm	.....	140ml 207ml	<ul style="list-style-type: none"> <li>For faecal smearing/incont.</li> <li>Use within close-fitting underwear</li> </ul>
 <input type="checkbox"/> MoliMed Comfort Midi <input type="checkbox"/> MoliMed Comfort Maxi	.....	212ml 404ml	<ul style="list-style-type: none"> <li>For slight urinary incont.</li> <li>Adhesive strip</li> <li>Use within close fitting underwear</li> </ul>
 <input type="checkbox"/> MoliCare Premium Form Normal <input type="checkbox"/> MoliCare Premium Form Normal+ <input type="checkbox"/> MoliCare Premium Form Extra <input type="checkbox"/> MoliCare Premium Form Extra+	.....	470ml 550ml 720ml 960ml	<ul style="list-style-type: none"> <li>For moderate to severe urinary/faecal incont.</li> <li>Ensure anatomical shape for fitting</li> <li>Use within close fitting underwear</li> </ul>
 <input type="checkbox"/> Molicare Premium Slip: <input type="checkbox"/> Extra S (60-90cm) <input type="checkbox"/> Extra M (90-120cm) <input type="checkbox"/> Extra L (120-150cm) <input type="checkbox"/> Extra Plus XS (40-60cm) <input type="checkbox"/> Extra Plus S (60-90cm) <input type="checkbox"/> Extra Plus M (90-120cm) <input type="checkbox"/> Extra Plus L (120-150cm) <input type="checkbox"/> Extra Plus XL (150-175cm)	.....	930ml 1050ml 1350ml 860ml 1040ml 1240ml 1430ml 1600ml	<ul style="list-style-type: none"> <li>For moderate to severe urinary/faecal incont.</li> <li>Use when a 2 piece system is not suitable</li> <li>Ensure you measure hips &amp; waist</li> </ul>

Please email documentation to [brch.continenceservice@nhs.net](mailto:brch.continenceservice@nhs.net) or send in the post to: Bladder & Bowel Service, Horfield Heath Centre, Lockleaze Road, BS7 9RR.

**To avoid incomplete assessments not being processed and sent back, please ensure you have followed the correct guidelines and have viewed the checklists for your specific service.**

**Community Nurses:** Please follow the Contenance Care Pathway and the other useful documentations located on the staff side of the Bladder and Bowel page (via BCH website). [www.briscomhealth.org.uk/staff/teams/bladder-bowel-service/](http://www.briscomhealth.org.uk/staff/teams/bladder-bowel-service/)

**Care Homes:** Please follow the Guidance for Residential Homes located on the Bladder and Bowel BCH website. [www.briscomhealth.org.uk/our-services/bladder-bowel-service/](http://www.briscomhealth.org.uk/our-services/bladder-bowel-service/)

**Nursing Homes:** Please follow the Guidance for Nursing Homes located on the Bladder and Bowel BCH website. [www.briscomhealth.org.uk/our-services/bladder-bowel-service/](http://www.briscomhealth.org.uk/our-services/bladder-bowel-service/)