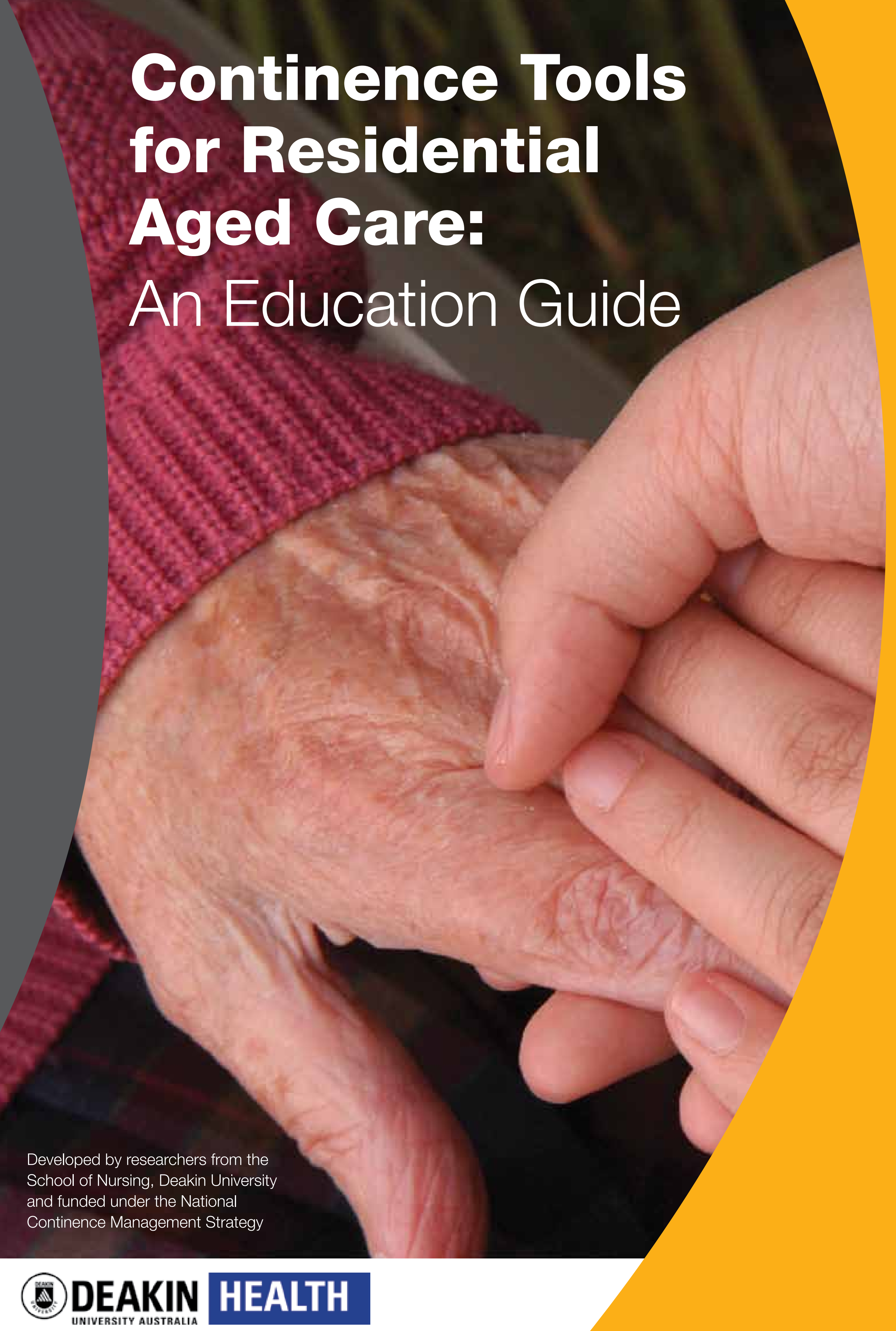
Continence Tools for Residential Aged Care: An Education Guide



Developed by researchers from the School of Nursing, Deakin University and funded under the National Continence Management Strategy

DEAKIN UNIVERSITY AUSTRALIA HEALTH

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Foreword

This guide, titled 'Continence Tools for Residential Aged Care: An Education Guide', was developed to assist Division 1 Registered Nurses, Division 2 Registered Nurses/Enrolled Nurses, Personal Carers/Careworkers or Nursing Assistants/Aids, to use the Continence Tools for Residential Aged Care. It provides information on how to conduct a continence assessment, develop a continence care plan and evaluate the effectiveness of care. It also includes a list of other continence resources.

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Other resources

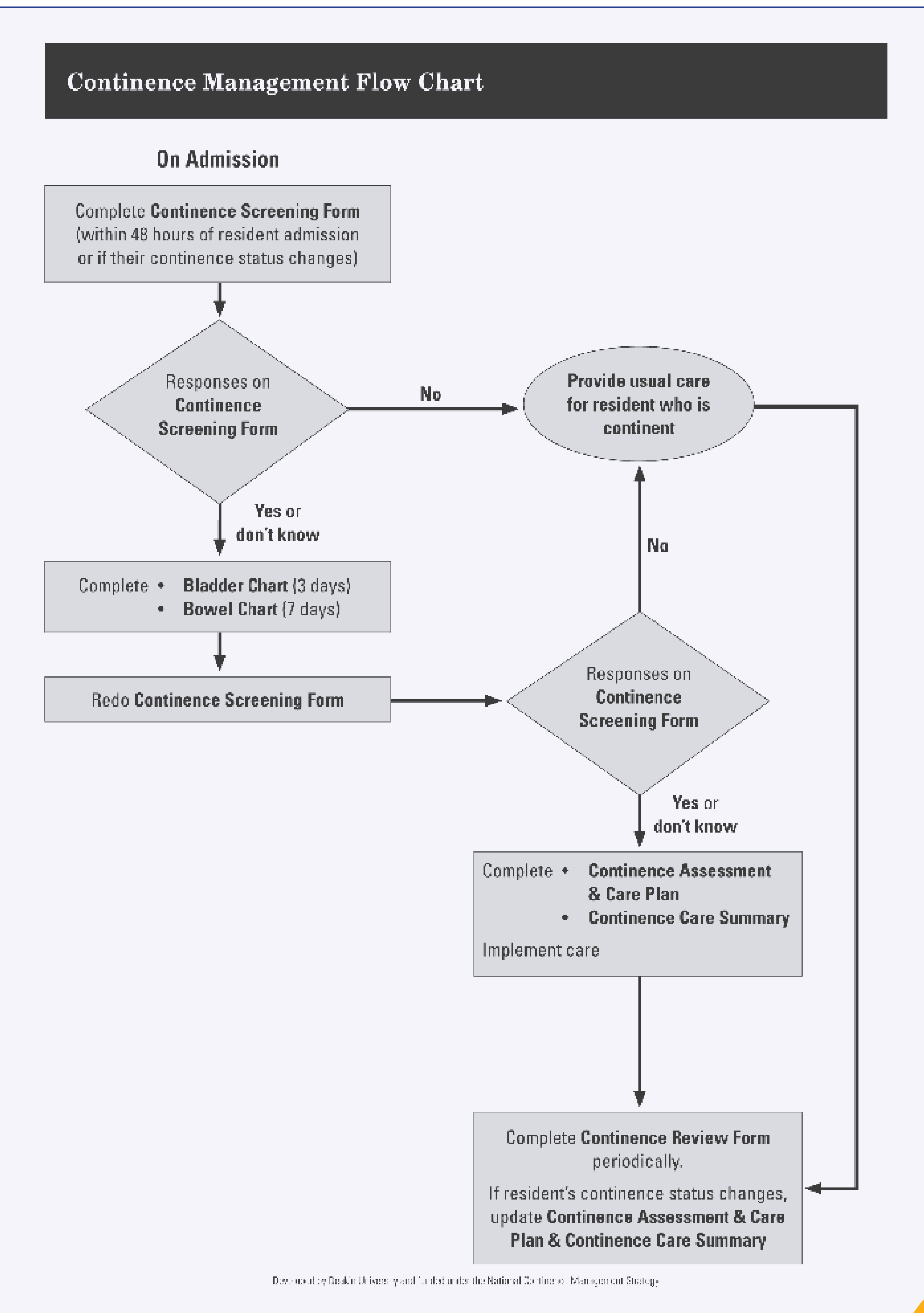
- The 'Continence Tools for Residential Aged Care'
- A PowerPoint Presentation titled *'Continence Tools for Residential Aged Care: An Education Guide'*
- Fact Sheet
- Poster

Copyright: Developed by Deakin University and funded under the National Continence Management Strategy.

Disclaimer: This education guide should be used as an adjunct to sound clinical judgement and institutional guidelines and protocols for the assessment and management of incontinence in residential aged care settings.

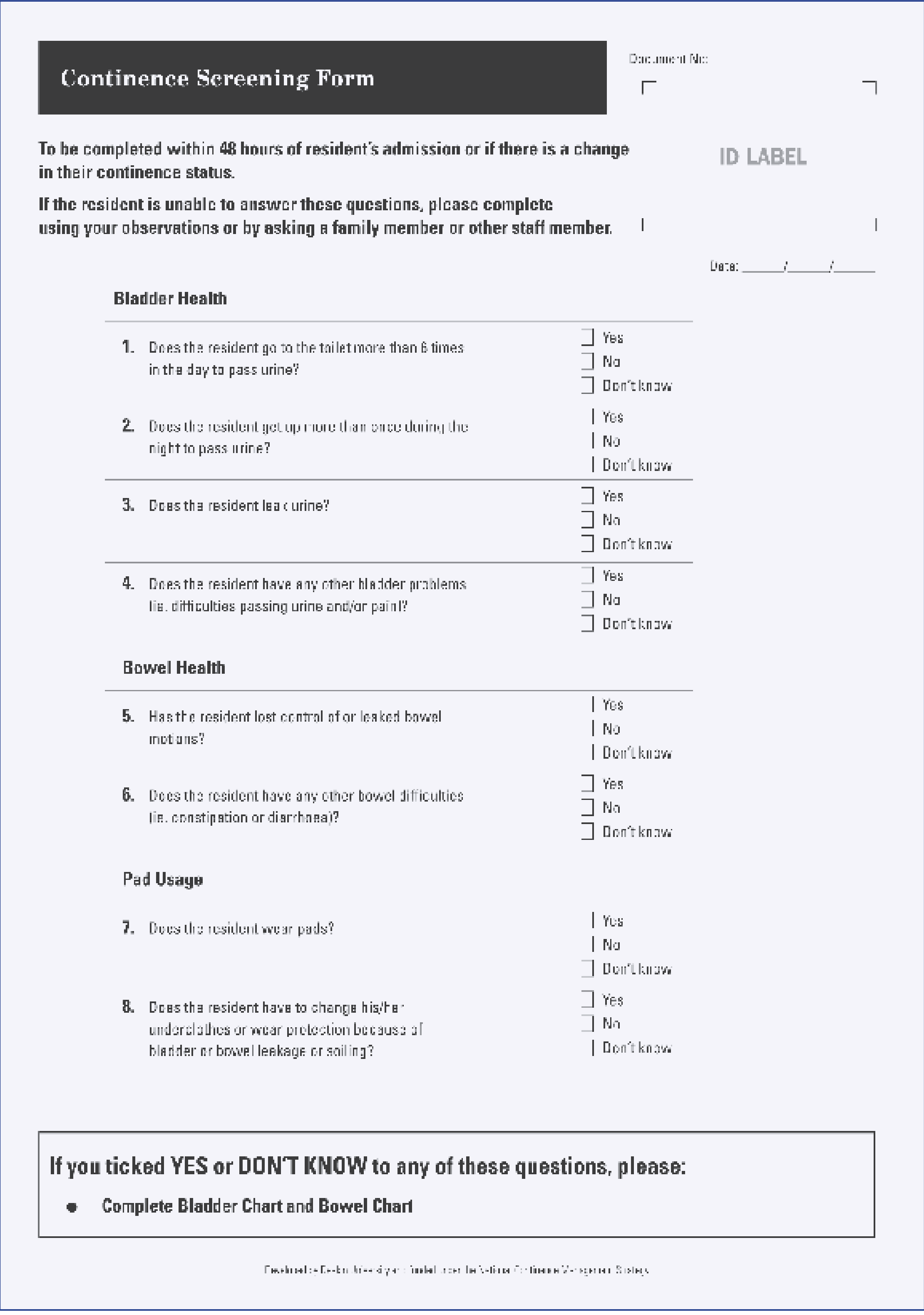
Photography: Courtesy of KMD Deakin University

1. The Continence Management Flow Chart



2. How to identify residents who require a continence assessment

Although almost 80 percent of residents have a bladder and/or bowel problem, not all residents require a comprehensive continence assessment. By completing the *Continence Screening Form* (see below), you will be able to identify which residents need to have a more thorough assessment of their bowel and bladder health.



Continence Screening Form

Document No:

ID LABEL

Date: ____/____/____

To be completed within 48 hours of resident's admission or if there is a change in their continence status.

If the resident is unable to answer these questions, please complete using your observations or by asking a family member or other staff member.

Bladder Health

1. Does the resident go to the toilet more than 6 times in the day to pass urine? ☐ Yes ☐ No ☐ Don't know
2. Does the resident get up more than once during the night to pass urine? ☐ Yes ☐ No ☐ Don't know
3. Does the resident leak urine? ☐ Yes ☐ No ☐ Don't know
4. Does the resident have any other bladder problems (ie. difficulties passing urine and/or pain)? ☐ Yes ☐ No ☐ Don't know

Bowel Health

5. Has the resident lost control of or leaked bowel motions? ☐ Yes ☐ No ☐ Don't know
6. Does the resident have any other bowel difficulties (ie. constipation or diarrhoea)? ☐ Yes ☐ No ☐ Don't know

Pad Usage

7. Does the resident wear pads? ☐ Yes ☐ No ☐ Don't know
8. Does the resident have to change his/her underclothes or wear protection because of bladder or bowel leakage or soiling? ☐ Yes ☐ No ☐ Don't know

If you ticked YES or DON'T KNOW to any of these questions, please:

- **Complete Bladder Chart and Bowel Chart**

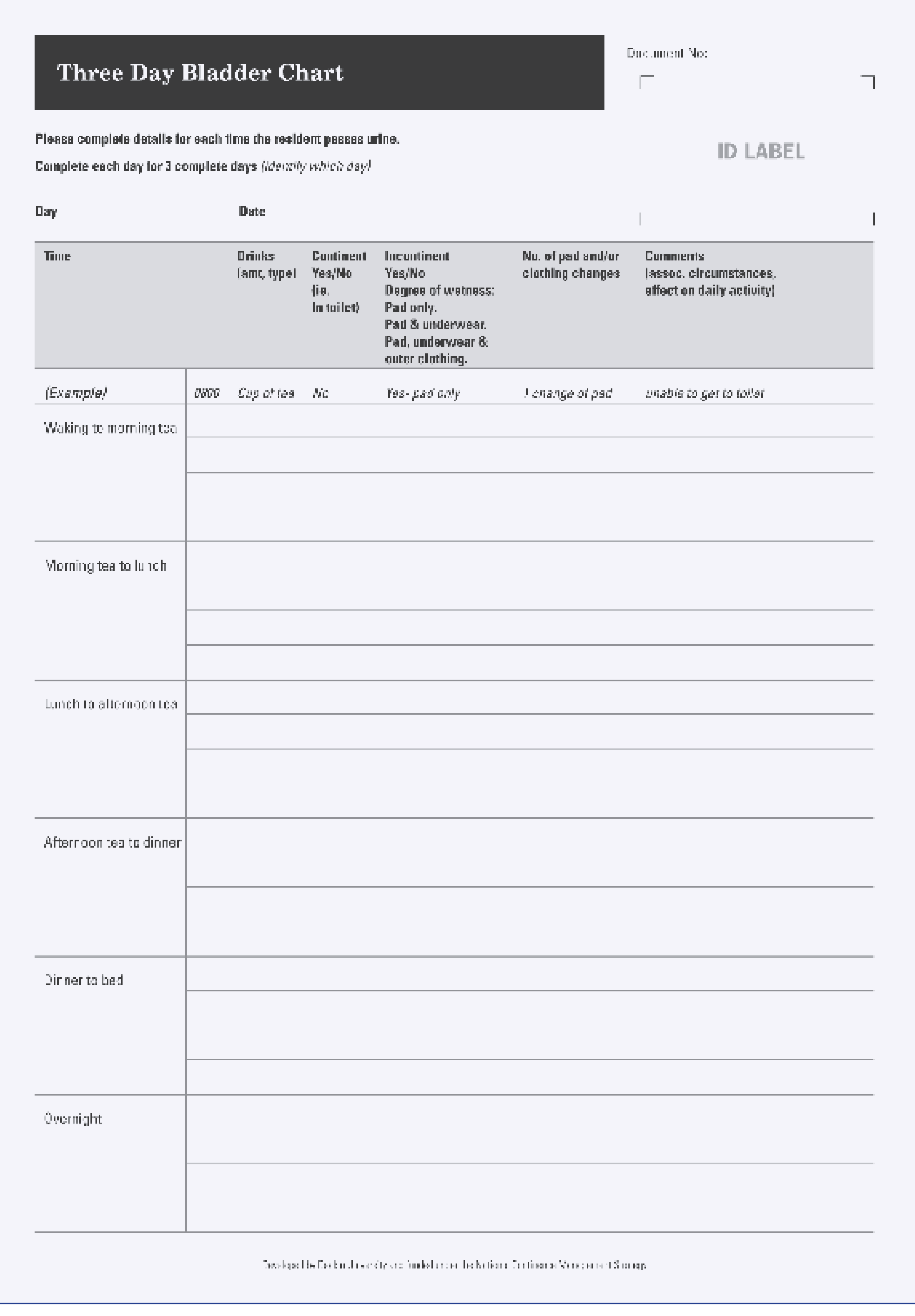
Frequently asked questions about completing the Continence Screening Form

When should the Continence Screening Form be completed?	The Continence Screening Form should be completed: • for all newly admitted residents (i.e. within 48 hours of their admission). • for established residents who develop new onset incontinence (i.e. if their continence status changes from continent to incontinent).
What should be done with the information from the Continence Screening Form?	If you ticked *'yes'* or *'don't know'* to any of the questions, commence the Bladder and Bowel Charts.

3. How to complete the Three Day Bladder Chart

By completing the *Three Day Bladder Chart*, you will obtain the following information:

- The time that the resident passes urine
- The type and volume of drinks consumed
- The degree of wetness if the resident is incontinent of urine
- The number of pad/ clothing changes when the resident is incontinent of urine
- Comments (i.e. the circumstances associated with the resident experiencing urinary incontinence).



Three Day Bladder Chart

Document No:

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Please complete details for each time the resident passes urine.

Complete each day for 3 complete days *(identify which day)*

Day

Date

Time		Drinks (amt, type)	Continent Yes/No (ie. In toilet)	Incontinent Yes/No Degree of wetness: Pad only. Pad & underwear. Pad, underwear & outer clothing.	No. of pad and/or clothing changes	Comments (assoc. circumstances, affect on daily activity)
(Example)	*0800*	*Cup of tea*	*No*	*Yes- pad only*	*1 change of pad*	*unable to get to toilet*
Waking to morning tea						
Morning tea to lunch						
Lunch to afternoon tea						
Afternoon tea to dinner						
Dinner to bed						
Overnight						

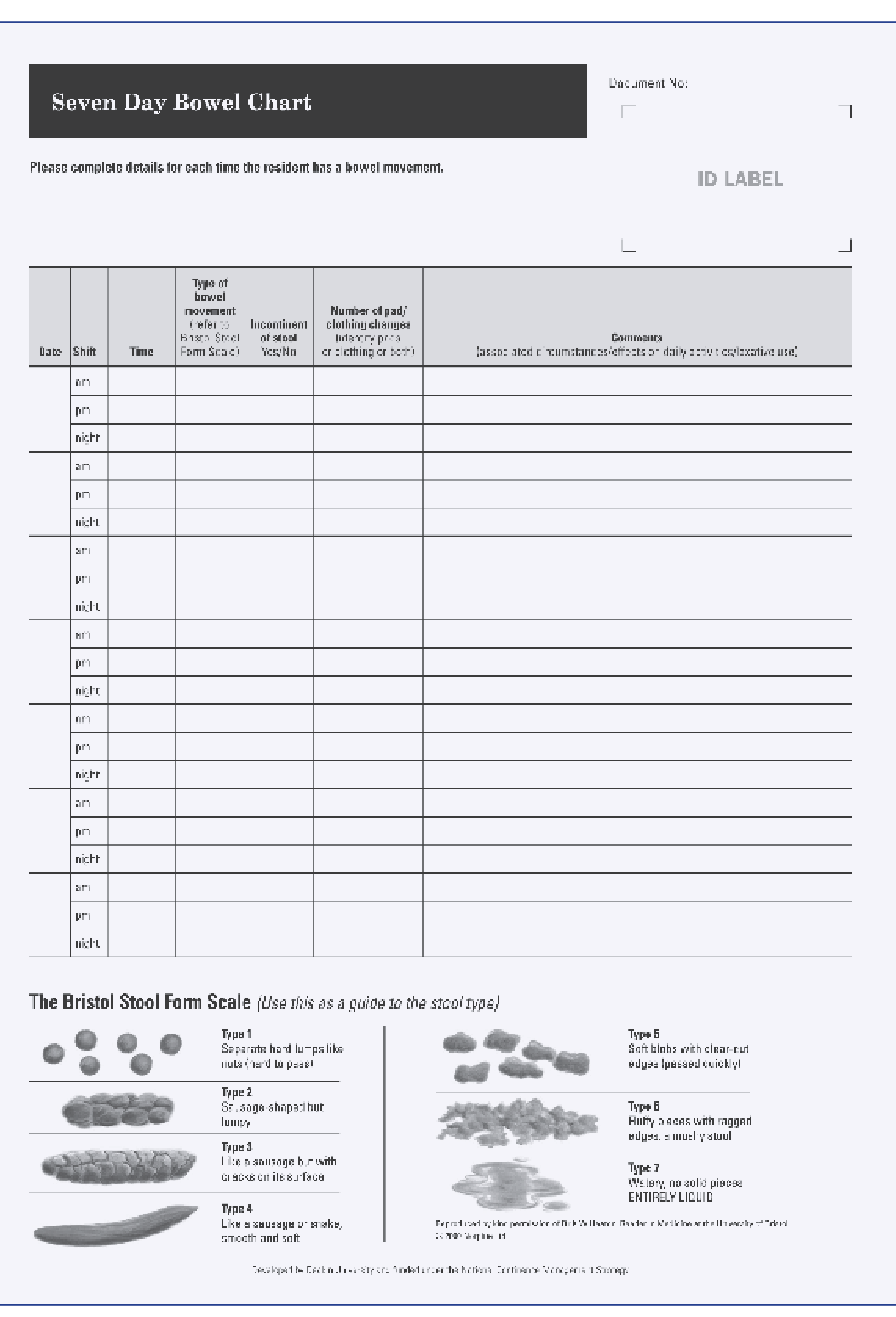
Frequently asked questions about completing the Three Day Bladder Chart

When should the Three Day Bladder Chart be commenced?	The best time to commence the Three Day Bladder Chart is when the resident is settled and familiar with their surroundings. This timing varies from resident to resident but usually it can be commenced one to two weeks after the resident is admitted to the facility. Other times that the Three Day Bladder Chart may be appropriate to use are when you are reviewing the resident's continence status and when you wish to monitor the effectiveness of care.
Why maintain the Chart for three days?	The Three Day Bladder Chart should be maintained for a minimum period of 3 complete and consecutive 24-hour periods (including day and night). If it is not possible to monitor the resident's bladder elimination over 3 consecutive days, the chart can be completed over 3 separate, complete 24-hour periods. Three days is the average time that it takes to identify residents' bladder patterns. Some residents may need a longer period of monitoring.
How frequently should residents' urinary continence status be checked?	It is preferable to monitor the frequency of the resident's bladder elimination and urinary continence status closely during the assessment period. More frequent observations provide more accurate information on which to base a care plan. The frequency of checks and the manner in which they are conducted should not interfere with the resident's usual activities.
How is information collected to complete the Three Day Bladder Chart?	Ideally, information to complete the Three Day Bladder Chart should be provided by resident's themselves, however, due to dementia and other health related conditions, this is often not possible. Identify if the resident is continent or not during the designated time periods. Discreetly observe for urine loss when providing personal care (i.e. during toileting or hygiene assistance). If the resident is using a pad, check for a wetness indicator (usually located on outside of pad). Also observe and document how many drinks the resident has within the designated time periods; what type and what amount.
What should be done with the information from the Three Day Bladder Chart?	Information from the Three Day Bladder Chart should be used to complete the Continence Assessment Form and Care Plan (Sections B & C). Another use of the information from the Three Day Bladder Chart is to assist you to complete sections 4 & 5 of the ACFI (Toileting and Continence). Review the information collected over a 3 day period to decide whether or not a resident has a predictable pattern of voiding. If yes, develop and put in place an individualised toileting program that is based on this pattern. If no, develop and put in place a fixed time toileting program (such as every 3 or 4 hours during the day).

4. How to complete the Seven Day Bowel Chart

By completing the *Seven Day Bowel Chart*, you will obtain the following information:

- The day that the resident has a bowel motion and on AM, PM or night shift.
- The time that the resident has a bowel motion.
- The type of bowel movement (refer to the Bristol Stool Form Scale on the Seven Day Bowel Chart).
- Whether or not the resident was incontinent of faeces.
- The number of pad/ clothing changes when the resident is incontinent of faeces.
- Comments (i.e. the circumstances associated with the resident experiencing faecal incontinence).



Seven Day Bowel Chart

Document No:

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Please complete details for each time the resident has a bowel movement.

Date	Shift	Time	Type of bowel movement (refer to Bristol Stool Form Scale)	Incontinent of stool Yes/No	Number of pad/ clothing changes (incontinence pads or clothing or both)	Comments (associated circumstances/effects on daily activities/laxative use)
	am					
	pm					
	night					
	am					
	pm					
	night					
	am					
	pm					
	night					
	am					
	pm					
	night					
	am					
	pm					
	night					
	am					
	pm					
	night					
	am					
	pm					
	night					

The Bristol Stool Form Scale *(Use this as a guide to the stool type)*

Type 1
Separate hard lumps like nuts (hard to pass)

Type 2
Sausage-shaped but lumpy

Type 3
Like a sausage but with cracks on its surface

Type 4
Like a sausage or snake, smooth and soft

Type 5
Soft blobs with clear-cut edges (passed quickly)

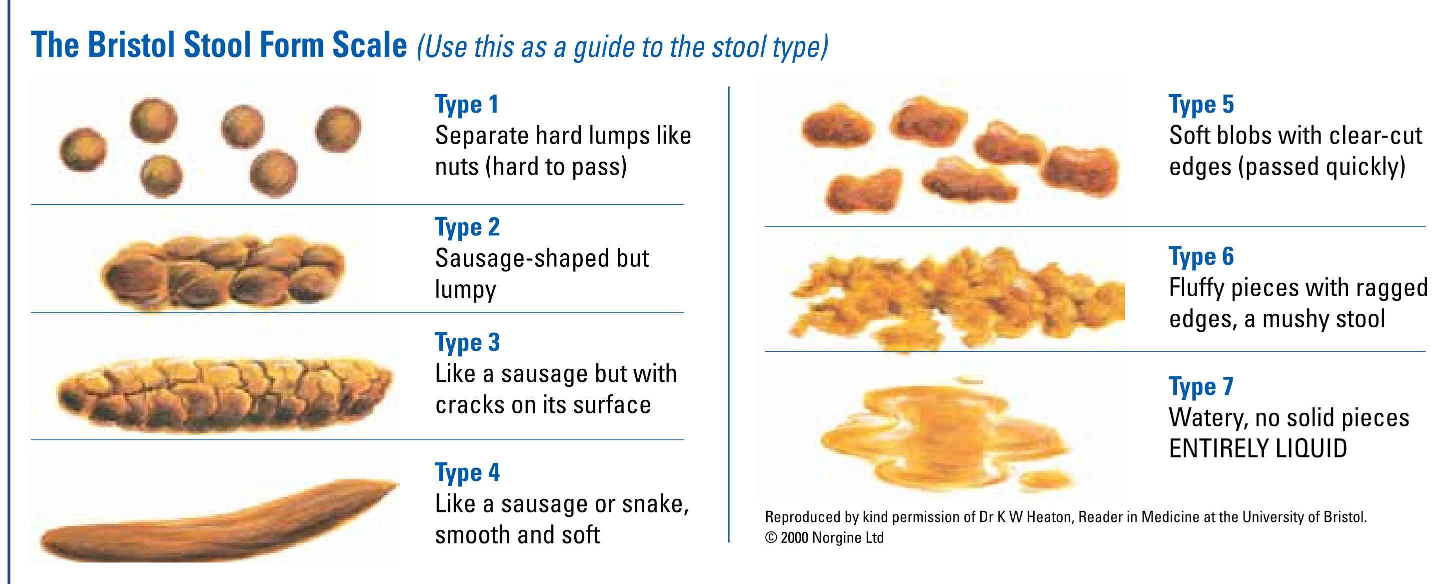
Type 6
Fluffy pieces with ragged edges, a mushy stool

Type 7
Watery, no solid pieces
ENTIRELY LIQUID

Frequently asked questions about completing the Seven Day Bowel Chart

When should the Seven Day Bowel Chart be commenced?	The best time to commence the Seven Day Bowel Chart is when the resident is settled and familiar with their surroundings. This timing varies from resident to resident but usually it can be commenced one to two weeks after the resident is admitted to the facility. Other times that the Seven Day Bowel Chart may be appropriate to use are when you are reviewing the resident's bowel management program and when you wish to monitor the effectiveness of care.
Why maintain the Chart for seven days?	The Seven Day Bowel Chart should be maintained for a minimum period of 7 complete and consecutive 24-hour periods (including day and night). If it is not possible to monitor the resident's bowel elimination over 7 consecutive days, the chart can be completed over 7 separate, complete 24-hour periods. Seven days is the average time that it takes to identify residents' bowel patterns. Some residents may need a longer period of monitoring.
How frequently should residents' bowel continence status be checked?	It is preferable to monitor the frequency of the resident's bowel elimination and bowel continence status closely during the assessment period. More frequent observations provide more accurate information on which to base a care plan. The frequency of checks and the manner in which they are conducted should not interfere with the resident's usual activities.
How is information collected to complete the Seven Day Bowel Chart?	Ideally, information to complete the Seven Day Bowel Chart should be provided by resident's themselves, however, due to dementia and other health related conditions, this is often not possible. Identify if the resident is continent or not during the designated time periods. Discreetly observe for faecal loss when providing personal care (i.e. during toileting or hygiene assistance). If the resident is using a pad, check this for soiling.
What should be done with the information from the Seven Day Bowel Chart?	Information from the Seven Day Bowel Chart can be used to complete the Continence Assessment Form and Care Plan and to develop a continence care plan that is responsive to the residents needs. In particular, it will help you to complete the section on Bowel assessment (Section B). Another use of the information from the Seven Day Bowel Chart is to assist you to complete sections 4 & 5 of the ACFI (Toileting and Continence). Review the information collected over the 7 day period to decide whether or not a resident has a predictable pattern of using their bowels. If yes, develop and put in place an individualised toileting program that is based on this pattern. If no, ensure the resident has the opportunity to use their bowel regularly. As there are some special techniques or strategies available to help people to develop regular bowel elimination, you might like to involve a Registered Nurse, Continence Nurse or the resident's General Practitioner.

5. The Bristol Stool Form Scale



What is the Bristol Stool Form Scale?

The Bristol Stool Form Scale is a visual aid designed to help you to classify the consistency or form of the stool. The seven types of stool are pictured on the left. The scale is widely used in practice and has a strong research base.

Why should the Bristol Stool Form Scale be used?

Stool consistency (i.e. stool form) is an important factor to consider in assessing bowel function. By referring to the Bristol Stool Form Scale, you will obtain more accurate assessment information than through other methods of evaluation.

What is a normal stool?

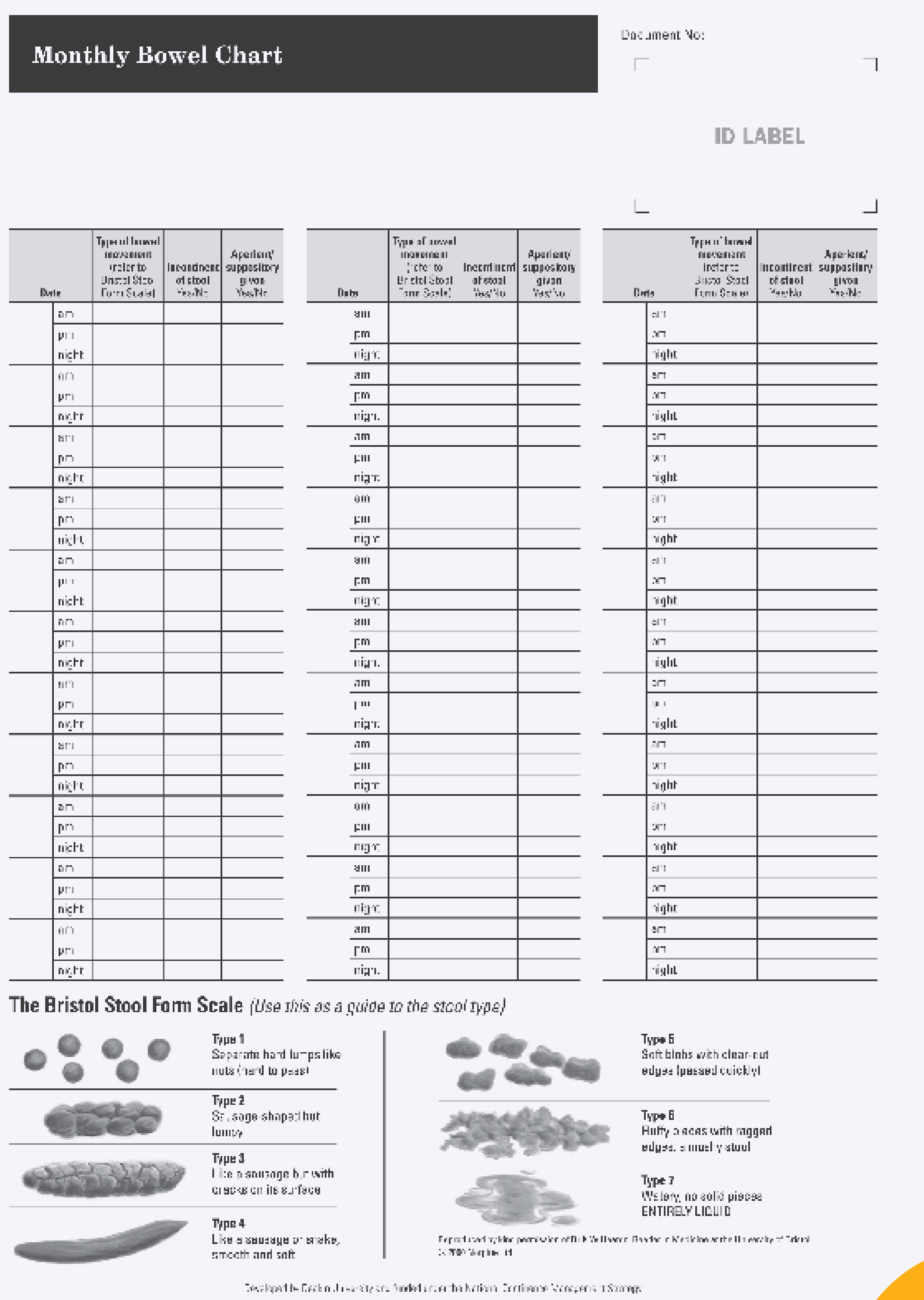
If the resident has types 1 and 2 stool, this indicates constipation. Types 3 & 4 are considered 'normal stools' and types 5-7 denote looser stools or diarrhoea. The most ideal stool type is type 4 as this is the easiest to pass.

6. The Monthly Bowel Chart

Some residents require ongoing monitoring of their bowel elimination pattern to assist you to identify whether or not aperients or other medications are required. The *Monthly Bowel Chart* is designed for this purpose. The best time to commence it is following completion of the resident's continence assessment.

By completing the *Monthly Bowel Chart*, you will obtain the following information:

- The day that the resident has a bowel motion and on AM, PM or night shift.
- The type of bowel movement (refer to the Bristol Stool Form Scale on the Bowel Chart).
- Whether or not the resident was incontinent of faeces.
- Whether or not the resident was given an aperients/suppository.



Monthly Bowel Chart

Document No:

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Date		Type of bowel movement (refer to Bristol Stool Form Scale)	Incontinent of stool Yes/No	Aperient/ suppository given Yes/No	Date		Type of bowel movement (refer to Bristol Stool Form Scale)	Incontinent of stool Yes/No	Aperient/ suppository given Yes/No	Date		Type of bowel movement (refer to Bristol Stool Form Scale)	Incontinent of stool Yes/No	Aperient/ suppository given Yes/No
	am					am					am			
	pm					pm					pm			
	night					night					night			
	am					am					am			
	pm					pm					pm			
	night					night					night			
	am					am					am			
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	night					night					night			

The Bristol Stool Form Scale *(Use this as a guide to the stool type)*

Type 1 Separate hard lumps like nuts (hard to pass)

Type 2 Sausage-shaped but lumpy

Type 3 Like a sausage but with cracks on its surface

Type 4 Like a sausage or snake, smooth and soft

Type 5 Soft blobs with clear-cut edges (passed quickly)

Type 6 Fluffy pieces with ragged edges, a mushy stool

Type 7 Watery, no solid pieces ENTIRELY LIQUID

7. How to complete the Continence Assessment Form and Care Plan

The *Continence Assessment Form and Care Plan* consists of a number of assessment cues (or questions). There is also a list of care options that are linked to these cues that guide continence management. It is divided into the following sections:

A. Assessment of toileting ability, cognition and mobility for continence care
B. Assessment of bladder and bowel pattern
C. Assessment of nutritional status
D. Assessment of skin care needs
E. Medical assessment
F. Assessment of resident's perspectives

The *Continence Assessment Form and Care Plan* also includes a *Continence Care Summary* that allows you to document the day-to-day continence care tasks for the resident. This form can be used as a daily work sheet as required.

Frequently asked questions about completing the Continence Assessment Form and Care Plan

Why should the Continence Assessment Form and Care Plan be completed?	Conducting a continence assessment will help you to identify the nature of the resident's bladder and/or bowel symptoms as well as factors that may be causing or contributing to these symptoms. Some residents have bladder and bowel symptoms that require a more specialised assessment. The form contains prompts to help you to identify which residents need more specialised assessment.
When should the Continence Assessment Form and Care Plan be commenced?	The complete set of tools should be completed within 28 days of the resident's admission. The best time to commence the Continence Assessment Form and Care Plan is when the resident is settled and familiar with their surroundings. This timing varies from resident to resident but usually a continence assessment can be commenced one to two weeks after the resident is admitted to the facility.

The Continence Assessment Form and Care Plan

SECTION A: Toileting ability, cognitive skills & mobility

Although continence may not be achievable for all residents, it is nevertheless, important to encourage all residents to participate as much as possible in toileting activities so that they remain as mobile and independent as possible. Another aspect to keep in mind is the resident's personal preferences for continence care.

Assessment cue	Rationale & care options
Does the resident know when they want to go to the toilet?	Some medical conditions can impair the resident's ability to identify the urge to pass urine or use their bowels. This could be due to a lack of sensation or because they are unable to interpret the sensation, or because they are unable to communicate the need for assistance. Observe the resident for individual behaviours such as agitation and pulling at clothing that indicate they need to use the toilet.
Can the resident tell you where the toilet is?	Some residents have medical conditions that make it difficult for them to identify the location and/or use of the toilet. Remind the resident to go to the toilet regularly and provide direction if required. Other strategies include placing the resident close to the toilet, leaving the toilet light on at night and ensuring the toilet is easy to identify.
Can the resident walk to the toilet independently?	The ability to walk is critical for the maintenance of continence. Mobility programs have been shown to improve resident's continence status. If the resident is unable to walk to the toilet or if this involves unnecessary risk or pain, consider the use of other devices (i.e. bedpans, urinals, commodes or absorbent pads).
Can the resident get on and off the toilet independently?	Although some residents may be able to complete some aspects of toileting, they may require assistance with other aspects, such as getting on and off the toilet. Assistive devices such as handrails and/or a raised toilet seat may provide the levels of support needed for residents to use the toilet with more independence.
Can the resident undress and dress themselves before and after toileting?	There are a number of factors and conditions that may make it difficult for residents to complete all aspects of the toileting procedure. Consider using clothing that is easy for the resident to manage if dressing/undressing is a challenge.
Can the resident use toilet paper and wipe him/herself?	Some residents may need help with this aspect of personal care. Provide assistance as required. Consider offering pre-moistened wipes.
Does the resident co-operate with staff when they assist with toileting or changing?	Some residents may have difficulty understanding staff efforts to provide continence care. The activity of removing the resident's clothing may be interpreted by them as an act of violation. If this is a problem, it is important to assist the resident to understand your actions. Respect their right to decline and suggest that you will come back later to see if they are ready.
Does the resident experience pain that restricts their toileting, transfer, clothing adjustment and/or hygiene?	Because pain can reduce a resident's mobility and exhaust their physical and emotional reserve, it may also deter them from going to the toilet. This is also true for people with dementia. If pain is a contributing factor, consider the use of other devices (i.e. bedpans, urinals, commodes) or continence products (i.e. absorbent pads).

The Continence Assessment Form and Care Plan (cont'd)

SECTION B: Bladder and bowel pattern

Most people pass urine 4-6 times a day and, 1-2 times at night (if >65yrs of age). If the resident passes urine too frequently or infrequently, they may require a medical assessment. If they need to pass urine at night, it is important to assess their risk for falling. You may need to develop a continence care plan for day and another plan for night.

The frequency of bowel elimination varies considerably from individual to individual. *Aim for residents to use their bowels regularly (at least 3 times per week)* and to pass a stool that is soft and formed (Type 3-4 on the Bristol Stool Form Scale). Refer to the Three Day Bladder Chart and Seven Day Bowel chart for assistance answering some of these questions.

Assessment cue	Rationale & care options
During the day, how many times does the resident need to pass urine/go to the toilet on average (from 7am-7pm)?	Some residents may have medical conditions that affect how often they pass urine. Congestive Cardiac Failure is one such condition. Urinary tract infections are another. Constipation and faecal impact may also cause bladder symptoms. Medications such as diuretics can also affect the frequency of passing urine. Because an older person's bladder generally holds less urine, people over the age of 65, often need to pass urine every 3-4 hours. It is important to consider whether or not there are any medical conditions or reversible factors that are causing the resident to pass urine frequency and if so, how bothersome the resident's frequency of passing urine is to them. If a resident passes urine too frequently or has trouble passing urine, this should be reported to the RN, Continence Nurse or GP. Difficulty with passing urine in elderly men may indicate a problem with the prostate.
During the night, how many times does the resident need to pass urine/go to the toilet on average (from 7pm-7am)?	It is normal for older people to pass more urine at night and to have the urge to pass urine 1-2 times. If this occurs more frequently, it is important to consider whether or not there are medical factors that need to be investigated. Another factor to consider is the resident's risk of falling at night as they attempt to respond quickly to the urge to pass urine. This will affect your management at night (i.e. consider a bedside commode/call bell being accessible etc).
Does the resident experience urine leakage during the day or night?	There are many possible reasons for residents' experiencing incontinence during the day and/or night. Reasons for daytime incontinence may differ from reasons for night-time incontinence. Conducting a continence assessment will help you to identify possible causes and a plan of action. Some residents will respond however to regular and timely toileting assistance.
Does the resident have a predictable pattern of passing urine (including urine leakage)?	If the resident has a predictable pattern of passing urine, they may respond to an individualised toileting program where you either prompt or assist them to the toilet at times that are based on their usual pattern. Alternatively, if there is no predictable pattern, they may respond to a fixed time toileting program. This involved taking the resident to the toilet at fixed regular intervals. If the resident is not suitable for a toileting program, you may choose to put in place a pad check and change program. This involves regular checks of the resident's continence status and changes of pads (if wet).
Does the need to pass urine or incontinence at night make it difficult for the resident to go back to sleep?	Getting up to pass urine at night is commonly experienced by older adults. For many, this is not a problem, however for some people, it is disruptive and they find it difficult to get back to sleep.

Assessment cue	Rationale & care options
Does the resident have a urinary catheter in place?	If the resident has a urinary catheter in place, it is important to document the reason for the catheter and to develop and put in place a catheter management plan that addresses the risks of infection, blockage, bypassing, trauma etc.
How often does the resident normally use their bowels?	Normal healthy bowel elimination is characterised by the following factors: • Regular bowel movements (frequency varies from person to person) • A stool that is brown in colour, soft and formed • The ability to recognise the urge (i.e. sensation) to use one's bowels – usually in the morning following breakfast and a warm drink • A stool that is easy to pass (i.e. no straining) • The ability to hold on until reaching the toilet • Feelings of satisfactory defecation. As people age, the bowel and the GUT are slower. For most older people, this change in bowel function does not cause problems. However, when combined with reduced mobility, reduced food and fluid intake, constipation may develop.
In the past two weeks has the resident leaked, or had accidents or lost control with stool/bowel motion?	There are many other factors that can combine to make it difficult for residents to have healthy bowel elimination. A continence assessment will help you to identify these factors.
Has the resident got any of the following symptoms when they use their bowels? • *Pain and discomfort* • *Straining* • *Bleeding* • *Hard, dry motions* • *Very fluid bowel motions*	These symptoms are often associated with constipation, faecal impaction or some other anal/rectal pathology.
Has the resident had a urine test (dipstick) done in the past 28 days? *pH* ________ *SG* ________ *Blood* ☐ *Yes* ☐ *No* *Nitrites* ☐ *Yes* ☐ *No* *Leukocytes* ☐ *Yes* ☐ *No*	Residents' urine should be tested on admission as a standard admission screening procedure and periodically (i.e. according to facility policies). Any abnormalities should be reported. Normal pH of urine may range from 4.5 to 8 and 7 is the point of neutrality. Normal SG in adults is > 1.000. Urine is normally free of blood, nitrates and leukocytes. The presence of any of these factors indicates the need for further investigation. The resident's GP should be promptly notified of any abnormalities.

The Continence Assessment Form and Care Plan (cont'd)

SECTION C: Nutrition (fluid & diet)

Aim for the resident to have 5-10 cups of fluid per day unless otherwise indicated and limit known bladder irritants (i.e. coffee, alcohol). Aim for the resident to have 30gm of dietary fibre per day unless otherwise indicated.

Assessment cue	Rationale & care options
Does the resident drink an adequate amount of fluid to maintain hydration and healthy bladder and bowel function (Refer to Three Day Bladder Chart & check colour of urine)?	Inadequate fluid intake can result in urinary frequency, urgency and urge incontinence because it may lead to either a UTI or to urine that is highly concentrated and irritative to the bladder. It may also result in the resident becoming constipated. Most people rely on thirst as an indication of the need to drink- older people are at risk of experiencing an impaired thirst mechanism, putting them at risk of dehydration. It is recommended that at least 1.5 litres of fluid in 24 hours (approx 5-10 cups per day) is required for bladder and bowel health. Some medical conditions or side effects of medications can result in people drinking excessive amounts of fluid which can contribute to increased urinary symptoms. Alternatively, some people associate drinking fluids with their urinary incontinence, and avoid drinking, leading to a deterioration of their symptoms. Encourage or assist the resident to have their preferred drinks regularly. Allow adequate time for resident to consume all of their drinks, and/or encourage relatives to assist if available. Offer decaffeinated drinks if caffeine is known to irritate the resident's urinary symptoms. Monitor resident's behaviour for signs of excessive drinking (more than 2.5 L per 24 hours) or avoiding drinks. Report to RN, CNA or GP if indicated who may recommend that the resident's fluid intake be recorded (over a 3-5 day period).
Does the resident eat an adequate amount of food with fibrous content to maintain healthy bladder and bowel function (Refer to nutritional assessment)?	Vegetables, fruit and many cereals contain fibre. Fibre is important to draw water into the faeces in the large intestine, enabling passage of formed, easy to pass stools. It also assists peristalsis- the muscular movement of the bowel that moves the faeces along. Offer the resident a variety of fibre sources. Some residents may prefer small meals more regularly. If the resident wears dentures, check them regularly for correct fit, and ensure they are in at meal times. You may like to refer the resident to a dietician who will be able to recommend foods high in fibre. Keep in mind that some residents have difficulty in swallowing and may need additional supplements and/or advice from a speech therapist.

The Continence Assessment Form and Care Plan (cont'd)

SECTION D: Skin care

Aim for the resident's skin to remain intact and free from rashes, excoriation and pressure ulcers.

Assessment cue	Rationale & care options
Does the resident's skin around their buttocks, groin and perineal area appear to: • *Be very thin or fragile* • *Be reddened* • *Be unusually pale* • *Have a discharge* • *Have a foul or bad smell* • *Be broken, ulcerated, have a rash or have lumps and blotches* • *Other (specify)*	Skin provides a barrier to elements such as heat, moisture and bacteria. Constant exposure to urine and faeces may put the skin at risk, as indicated by the symptoms listed. For example, presence of a foul, smelling discharge may indicate fungal infection. Urine and faeces (especially presence of both on the skin) may lead to irritant dermatitis, characterised by red and thin skin. Allergic dermatitis may result from exposure to an allergen such as washing powder or a particular containment aid. If a resident is incontinent, cognitively impaired and immobile, they are at greater risk of friction and shear related injury and pressure ulcers. To avoid skin 'break down' wash and dry the skin soon after incontinent episodes. Avoid using scented soap. There are many 'pH neutral' products available. Apply skin creams as directed. Avoid thick layering of barrier creams as these can rub off on the pad, rendering it ineffective at absorbing the urine. Ensure the pad that has been selected is of good quality and adequate for the degree of wetness – if a pad 'leaks' it is likely the skin will be unnecessarily exposed to moisture. If you are concerned about the appearance of the skin, i.e. there is an ulcer, discharge or foul odour, report to the RN, CNA or GP for assessment.
Is the resident currently using a continence product to manage their incontinence?	The ability to maintain social continence (incontinence managed or contained with products) is crucial to one's sense of well being. As many residents admitted to a residential aged care facility have a pre-existing problem of incontinence, they may have already established an effective management strategy. It is important to consider their past management and their personal preferences when assisting them to choose the most appropriate form of continence management. When choosing a pad, other factors to consider include the cost, the type of incontinence, the absorbency of the product, the shape and comfort , the disposability and whether or not the resident can manage the care associated with it.

The Continence Assessment Form and Care Plan (cont'd)

SECTION E: Medical Factors

It is important to distinguish between residents who have incontinence that may be caused by a potentially reversible cause/condition and residents whose incontinence is chronic and not responsive to treatment. Identifying potentially reversible conditions which may be causing or exacerbating incontinence can be challenging in residents who have also have dementia or health conditions that make it difficult for them to communicate their needs. Confusion associated with delirium for example may be difficult to distinguish from confusion associated with dementia. Similarly, incontinence, urinary frequency or increased confusion may be the only symptoms evident in residents with bladder infections.

For these reasons, Section E may need to be completed by an RN, Continence Nurse or GP and with reference to the resident's medical history. Refer to pages 24–26 for further information on symptoms or factors that warrant further attention.

Conducting a continence assessment also involves deciding with the resident and/or family members about the appropriateness of different treatment options (including referral to a specialist). International guidelines for continence care advocate for frail older adults to have equal access to assessment and treatment options as other members of the community. The following is a list of different options for the treatment of incontinence.

Assessment cue	Rationale & care options
Medication	There are many different medicines that target the condition /symptom of incontinence. The choice of drug depends on the underlying cause of the problem and the type of incontinence. Consider the potential for side effects and monitor the resident during treatment.
Bladder training	Bladder training aims to increase a person's bladder capacity, the interval between voiding and ability to 'hold on' (defer voiding). This is done by progressively increasing the interval between voiding over a number of weeks. Bladder training is suitable for individuals who are cognitively alert and able to follow a structured program.
Electrical stimulation	Electrical stimulation involves applying a low grade electrical current to pelvic floor muscles to stimulate the pelvic muscle to contract. It is usually administered by a Physiotherapist who specialises in pelvic floor dysfunction or by a Continence Nurse. Electrical stimulation is suitable for individuals who are cognitively alert and able to follow a structured program.
Pelvic floor muscle training	Pelvic floor muscle exercises are designed to strengthen the pelvic floor muscles through actively tightening and lifting them at intervals. Weakness of the pelvic floor muscles may result in incontinence. Pelvic floor muscle training is suitable for individuals who are cognitively alert and able to follow a structured program.
Referral to GP, Continence Nurse, Urologist, Geriatrician, Gynaecologist or Physiotherapist	There are many different health practitioners who specialise in the treatment of incontinence and treatment options vary depending on the underlying cause of the person's incontinence. For example, a referral to a gynaecologist would be indicated if a resident has a prolapse. By contrast, a urologist would be indicated if a male resident has difficulty voiding. It is important to liaise with the resident and the resident's GP to determine if a referral to a specialist is indicated.

The Continence Assessment Form and Care Plan (cont'd)

SECTION F: Resident's perspectives

It may not always be possible to obtain accurate information from the resident about their preferences for continence care or about how they feel about incontinence. At the same time, their perspectives and their past management should be considered. It may be appropriate to ask a nominated family member for information to complete this section.

Keep in mind that some residents may hold low expectations of improvement. An important aspect of your role is to provide information about healthy bladder and bowel elimination and to ensure that the resident has access to further assessment and intervention as required.

Assessment cue	Rationale & care options
If you are experiencing a bladder and/or bowel problem, what kind of assistance would you prefer (may tick more than one option) • *No assistance* • *To be assisted to go to the toilet at ....* • *To wear pads during the day* • *To wear pads during the night* • *To have a laxative (bowel)* • *To be seen by a specialist for further investigation* • *Other*	Ideally, all residents should be consulted about their preferences for continence care. Family members may also be a valuable source of information about the resident's preferences or past coping strategies. Whilst it may not be possible to accommodate all of these preferences, they should nevertheless be considered.
If you are experiencing a bladder problem, how much of a problem is this to you? • *No problem* • *A bit of a problem* • *Quite a problem* • *A severe problem*	Asking the resident about the extent to which they are affected by bladder and/or bowel symptoms conveys respect for the resident. Incontinence is commonly associated with depression and reduced quality of life in older persons. If a person appears unconcerned about incontinence, you might like to consider the possibility that they may be depressed especially if they have experienced other losses in their life.
If you are experiencing a bowel problem, how much of a problem is this to you? • *No problem* • *A bit of a problem* • *Quite a problem* • *A severe problem*	Some bladder and bowel symptoms may be more bothersome to a resident than other symptoms. The degree to which the resident is bothered by their symptoms should be considered when deciding whether or not to seek further specialist advice.
If you are wearing a continence product, does it keep you dry and comfortable?	If the resident is using a continence product such as a pad, it is important that it fits the resident, absorbs any incontinence and protects their skin, underwear and outer clothing.

The Continence Assessment Form and Care Plan (cont'd)

The Continence Care Summary

The *Continence Care Summary* allows you to summarise and document the information obtained by completing the *Continence Assessment Form and Care Plan*. It is an additional and optional care plan form.

Some facilities may like to use it as a daily work sheet so that staff are familiar with the day-to-day continence care needs of each resident. Keep in mind that if the resident's continence status changes, both the *Continence Assessment Form and Care Plan* and the *Continence Care Summary* (if used), need to be updated.

Continence Care Summary

1. Is the resident
   - Incontinent of urine ☐ Yes ☐ No
   - Incontinent of faeces ☐ Yes ☐ No

2. What level of assistance is required to support toileting
   - ☐ N/A, unable to use toilet
   - ☐ No assistance required (is independent)
   - ☐ Requires supervision (i.e. prompting, reminding and directional support)
   - ☐ Requires physical assistance ☐ One person assist ☐ Two person assist ☐ Lifting equipment ☐ Other

3. Behaviours that indicate need to toilet
   - ☐ Restless ☐ Wandering
   - ☐ Pulls at clothes ☐ Other

4. Resident's day time toileting / pad check & change program

	7am	8am	9am	10am	11am	noon	1pm	2pm	3pm	4pm	5pm	6pm	7pm
Toileting times													
Pad check & change times													

5. Resident's night time toileting / pad check & change program

	7pm	8pm	9pm	10pm	11pm	midnight	1am	2am	3am	4am	5am	6am	7am
Toileting times													
Pad check & change times													

6. Resident's preferences for continence care *(if resident is able to indicate)*

   a) **During the day**
   - ☐ No assistance
   - ☐ Assistance to go to the toilet at ____________ *(specify times)*
   - ☐ To wear pads *(specify type)* ____________
   - ☐ Other

   b) **During the night**
   - ☐ No assistance
   - ☐ Assistance to go to the toilet at ____________ *(specify times)*
   - ☐ To wear pads *(specify type)* ____________
   - ☐ Other

7. Individual requirements for regular bowel elimination
   - ☐ No additional requirements
   - ☐ Encourage resident to sit on toilet for bowel action after breakfast each day
   - ☐ Encourage additional dietary fibre *(specify type)* ____________
   - ☐ Encourage additional fluid *(specify amount & type)*
   - ☐ Ensure laxative administration *(specify)*

8. Individual requirements for skin care
   - ☐ No additional requirements
   - ☐ Apply ____________ cream after each pad change

9. Other ____________

7

8. How to review residents' continence status

Frequently asked questions about completing the Continence Review Form

Why should the Continence Review Form be completed?	While the resident's continence status may remain the stable, it may also change – particularly if their health deteriorates. It is important to regularly review the resident's continence status and to update their continence care plan using the Continence Assessment Form and Care Plan (& Continence Care Summary – if used). By identifying changes in a resident's continence status early, you will be able to address potentially reversible conditions in a timely manner, or improve their quality of life by providing symptomatic treatment.	
When should the Continence Review Form be completed?	Once the initial continence assessment and care plan has been completed, we suggest the resident's continence status be reviewed regularly. The timeframes should be flexible, and at the discretion of the Registered Nurse.	
What information should be obtained in relation to Continence Review Form?	The resident may not require a 'full' re-assessment (completion of all the continence tools) - but completion of the relevant section of the Continence Assessment Form and Care Plan. A review involves responding to the following questions: **Has the resident had their continence status assessed in the last 12 months?** (This includes Three Day Bladder Chart, Seven Day Bowel Chart and the Continence Assessment Form and Care Plan.)	
	☐ **Yes:** continue on with the next review questions.	☐ **No:** Consider screening the resident for continence problems using the Continence Screening Form.
	Have all sections of the Continence Assessment Form and Care Plan been completed?	
	☐ **Yes:** continue with the review.	☐ **No:** Complete the relevant areas and update Continence Assessment Form and Care Plan (and Continence Care Summary) if indicated.
	Has there been any change in the resident's continence status since the last review? Review the assessment and care plan, and make a judgement about whether the information is still current.	
	☐ **Yes:** Re-assess the relevant area, and amend care plan as required. The resident's continence status should then be reviewed soon after.	☐ **No:** Continue with review.
	Does the resident's continence care plan need to be changed? Review the responses to the above questions, and review the care plan if not already completed.	
	☐ **Yes:** Amend care plan as indicated by re-assessing the resident in relevant areas. Repeat review soon after.	☐ **No:** Review residents continence status regularly.

9. Respecting residents' rights during a continence assessment

As with any other aspect of conducting a continence assessment, it is important to be sensitive to the private nature of resident's bladder and bowel elimination habits. For this reason, the way in which information is obtained about a about a resident's continence status, frequency of voiding, frequency of using their bowels or stool type should be done discreetly.

It may not always be possible to obtain information about a resident's bladder and bowel habits, however in the context of providing day-to-day personal care to residents, residential aged care staff are generally well placed to discreetly observe and identify signs and symptoms that will help to provide a comprehensive continence assessment.

Some residents may resist staff attempts to provide continence care: particularly residents who have dementia and who may misinterpret staff actions. For example, the activity of checking the resident's continence status may be interpreted as an act of violation. It is important to respect residents' right to decline care and to privacy. If this is a concern, options include conducting a case conference to determine the best approaches for the resident and/or to seek advice from health professionals with expertise in this area.

10. Linking the Continence tools to the Aged Care Funding Instrument

In March 2008, the Department of Health and Ageing introduced an Aged Care Funding Instrument (ACFI) as a resource allocation instrument for residential aged care. When completed, the ACFI allows residents care needs to be categorised as low, medium or high. Funding is allocated to the facility according to these categorisations. The ACFI focuses on the main areas that discriminate care needs among residents. These are:

- Residents needs in relation to activities of daily living
- Residents' behaviour
- Residents' needs for complex health care.

ACFI 4 Toileting

To determine the level of funding (i.e. subsidy) that a facility can claim to be able to meet the toileting needs of the resident, residential aged care staff have a responsibility to collect and submit information on the resident's day-to-day toileting needs and to complete a Toileting Checklist. Staff are required to indicate the level of assistance required by the resident 1) to use the toilet and 2) while they manage the toileting activity. The resident is rated as either independent, requires supervision or requires physical assistance (DoHA, 2008). The *Continence Tools for Residential Aged Care* include assessment cues that allow you to collect the relevant information to complete the DoHA Toileting Checklist.

ACFI 5 Continence

To determine the level of funding (i.e. subsidy) that a facility can claim to be able to meet the continence care needs of the resident, residential aged care staff have a responsibility to collect and submit information on the frequency of incontinence experienced by a resident over a predefined period of time. In order to claim the subsidy, staff are required to complete a 3-day Urine Continence Record and a 7-day Bowel Continence Record. The *Continence Tools for Residential Aged Care* include a Three Day Bladder Chart and a Seven Day Bowel Chart that can be used to collect the relevant information.

11. Bladder and bowel symptoms and conditions that warrant further attention

The *Continence Tools for Residential Aged Care* are designed to be completed by any level of staff. At the same time, it is important that all levels of staff are able to work together as a team and to identify bladder and bowel symptoms that warrant further attention. Although incontinence is not a life threatening condition, it is usually a sign of an underlying problem or health condition. To assist staff to identify residents who require further assessment, the tools include a number of alerts for staff to notify a Registered Nurse or Enrolled Nurse, Continence Nurse or the resident's General Practitioner.

Symptoms or factors that warrant further attention	Rationale
Resident resistance to assistance with toileting or changing	The resident may have an underlying condition that is causing them to resist care. This may be modifiable and require a behavioural management plan. Consider also whether or not the resident understands the care that is required and how they might interpret staff actions.
Voiding < 3 times during day	If the resident has difficulty voiding and/or voids infrequently, this may indicate a prostate problem (in men) or a neurological problem that results in incomplete bladder emptying. The symptom should be considered in relation to other symptoms (i.e. a sensation of incomplete bladder emptying etc). A medical assessment may be warranted.
Voiding > 6 times during the day	If the resident voids frequently during the day and/or night, this may indicate an underlying health problem that requires attention or it may be the result of medication. The symptom should be considered in relation to other symptoms (i.e. urgency, urge incontinence, symptoms of UTI etc). A medical assessment may be warranted.
Voiding > 2 times during the night	
The use of a urinary catheter	Residents with indwelling urinary catheters are at high risk for developing bladder infection. It is important to develop a catheter care plan that minimises catheter related problems. A medical assessment and/or involvement of a Continence Nurse may be warranted. The catheter should not be removed unless it is clear that it is safe to do so and that the resident will be able to independently void. Catheters should be avoided for continence management unless there is a clear benefit to the resident.
Bowel motions < 3 times per week	Individual vary widely in how frequently they use their bowels, however most people defeacate 3 times a week or more. If they defeacate less than 3 times a week, and also have a hard stool that is difficult to pass, this may indicate constipation. Healthy bowel elimination is primarily characterised by regular bowel movements, a soft, formed stool and a stool that is easy to pass (i.e. no straining). The resident may require increased fibre, fluid, activity or laxatives to achieve this.
Pain and/or discomfort when using bowels	Pain/discomfort during defeacation is not normal and should be investigated. It may indicate an underlying pathology such as haemorrhoids or they may be constipated.

Symptoms or factors that warrant further attention	Rationale
Straining to use bowels	Some straining to use bowels is normal. Excessive straining indicates constipation and/or an underlying pathology (i.e. neuropathic damage). Keep in mind that people with chronic health conditions may have difficulty in achieving abdominal pressure that facilitates bowel clearance.
Bleeding when using bowels	Bleeding during defeacation is not normal. It may indicate haemorrhoids or other underlying pathology.
Hard, dry bowel motions	Bowel motions should be soft and formed. Refer to the Bristol Stool Form Scale for assistance in differentiating between a healthy and unhealthy motion. There are numerous factors that result in motions that are too hard (i.e. medication side effects, inadequate fluid, exercise and fibre) or in motions that are too loose (i.e. diet, irritable bowel syndrome, gastroenteritis, medication side effects etc).
Very fluid bowel motions	
Urine Ph	7 is the point of neutrality on the pH scale. The lower the pH, the greater the acidity of a solution; the higher the pH, the greater the alkalinity. Urine pH is an important screening test for the diagnosis of renal disease, respiratory disease, and certain metabolic disorders. Depending on the person's acid-base status, the pH of urine may range from 4.5 to 8. Levels above or below this range warrant attention.
Urine specific gravity	Specific gravity measures the kidney's ability to concentrate or dilute urine in relation to plasma. Because urine is a solution of minerals, salts, and compounds dissolved in water, the specific gravity is greater than 1.000. The more concentrated the urine, the higher the urine specific gravity. A low specific gravity may indicate renal disease and certain metabolic disorders (i.e. diabetes insipidus). The normal specific gravity range in urine is 1.020 -1.030 g/ml. Levels above or below this range warrant attention.
Blood in urine	Otherwise known as 'haematuria,' blood in the urine can be visible to the naked eye or it may be microscopic. There are many possible causes of haematuria including urinary tract infection, inflammation/infection of the prostate, stones, and injury to any part of the urinary tract, excessive exercise, certain medications, (i.e. blood thinning agents), kidney disease, and/or cancer of the kidney, prostate or bladder. If the resident has haematuria, it should be promptly investigated.
Nitrates in urine	Under normal conditions, urine is sterile and free from bacteria, viruses and fungi. The presence of nitrites in urine indicates a urinary tract infection. This should be further investigated.
Leukocytes in urine	The presence of leukocytes in urine is indicative of a urinary tract infection. This should be further investigated.
Impaired skin integrity	If the resident has impaired skin integrity, they will require a care plan that specifically addresses this issue. A Wound Care Consultant may be able to provide additional advice and assistance.

11. Bladder and bowel symptoms and conditions that warrant further attention (cont'd)

Symptoms or factors that warrant further attention	Rationale
Delirium	Delirium causes acute confusion which may result in the resident being unable to perform toileting tasks and/or communicate need for assistance.
Bladder infection	Bladder infections cause bladder irritation which in turn can cause symptoms of urgency and urge incontinence.
Constipation	Constipation can affect the bladder by causing symptoms of urgency and urge incontinence, or pressure caused by constipation/faecal impact may affect bladder emptying.
Irritable bowel syndrome	Irritable bowel syndrome can cause symptoms of faecal urgency, faecal incontinence or alternatively, may result in constipation and incomplete bowel emptying. It often responds to dietary measures.
Atrophic vaginitis	Atrophic vaginitis is caused by a lack of oestrogen to the walls of the vagina is common in older women. It results in thinning of the vaginal wall and symptoms of stress incontinence. It also causes vaginal irritation. Local oestrogen therapy may be indicated.
Unstable diabetes	Unstable diabetes can cause urinary frequency, urgency and urge incontinence because of the presence of glucose in urine – which in turn can be irritating to the bladder wall. Longstanding diabetes may also cause damage to the nerve supply to the bladder and/or bowel. Stabilising the resident's diabetes can improve bladder and bowel function.
Depression	Depression is common in older adulthood and particularly among individuals with multiple health problems. Depression can lessen a person's motivation to engage in self care activities – including continence care.
Enlarged prostate	As men age, their prostate increases in size and in some cases, can result in voiding problems. Symptoms include urinary frequency, difficulty passing urine (hesitancy), nocturia and a sense of incomplete emptying. A referral to a urologist may be indicated.

12. Medications that may affect continence

Many residents take either prescribed or over the counter medications (including laxatives). Although medications are important for managing specific conditions, many have side effects that can affect bladder and/or bowel function. For example, laxatives are the most common cause of faecal incontinence in residential aged care settings.

Similarly, diuretics (commonly used to manage chronic heart conditions) give people a strong sensation of urinary urgency that prompts them to rush to the toilet. During its peak effect, diuretics also give people a sense of wanting to pass urine frequently. It is important to inform the resident's General Practitioner of any possible side effects so that their medication can be reviewed.

The following is a list of medications that commonly affect continence:

Medication type	Example/s	Effect on bladder and/or bowel function
Alpha-agonists	Pseudoephedrine	Found in many nasal decongestants. Can cause voiding difficulties in men.
Anticholinesterase	Neostigmine	For the management of Myasthenia gravis and irritable bowel syndrome. Can contribute to urinary incontinence due to relaxation of the bladder sphincter.
Anti-hypertensives • *Alpha-adrenergic blockers* • *Calcium channel blockers*	Minipress	Prescribed for the management of hypertension. Alpha-adrenergic blockers can cause increased urinary leakage.
	Nifedipine	Calcium channel blockers can lead to urinary frequency and increased need to pass urine at night.
Antimuscarinic medications, or anticholinergics	Hyoscine	Used to dry salivary and respiratory secretions.
	Propantheline	An anti-spasmotic sometimes used to manage bladder hyperactivity.
		These medications can cause voiding difficulties and may contribute to constipation.
Antimuscarinic side effects • *Antihistamines* • *Tricyclic antidepressants*	Phenergan Avomine Amitriptyline	Used to treat allergies, motion sickness. For management of depression. Both of these can decrease awareness of the need to pass urine. Tricyclic antidepressants can also cause voiding difficulties.
Antipsychotics	Haloperidol Clozapine Lithium	For the management of psychotic illnesses such as schizophrenia. Can decrease awareness of the need to pass urine and voiding difficulties.

12. Medications that may affect continence (cont'd)

Medication type	Example/s	Effect on bladder and/or bowel function
Barbiturates	Phenobarbital	Anti convulsant medication used in epilepsy. Can decrease awareness of the need to pass urine.
Benzodiazepines	Temazepam Diazepam	Used for sedation, i.e. management of insomnia. Contributes to decreased awareness of the need to pass urine, and impaired mobility.
Cytotoxics	Cyclophosphamide	For the treatment of cancers. Can result in a condition called Haemorrhagic cystitis - inflammation of the bladder leading to haemorrhage.
Diuretics	Lasix Spironolactone	Encourages urine excretion. Some residents may experience urinary urgency, frequency and/or incontinence and dehydration.
Homeopathic medication	St John's Wort	Treatment of depression. Has been associated with voiding difficulties.
Laxatives	Coloxyl with Senna Lactulose Movicol	There are many types of laxatives to soften the stool and make it easier to pass. If overused, they can result in loose stools, faecal urgency and frequency.
Muscle relaxants	Baclofen	Used to manage conditions such as Multiple Sclerosis. It causes relaxation that can often affect the pelvic floor muscles, therefore contributing to incontinence.
Opiate, Opioid and Narcotic analgesia	Morphine Panadeine Forte Oxycontin	Used to treat moderate to severe pain. Can cause sedation, voiding difficulties and contribute to constipation.
Xanthines	Theophylline Caffeine – tea and coffee	Theophylline is used to treat asthma. Can cause urinary urgency and dehydration.

Australian Medicines Handbook (2008); Getliffe, K & Dolman, M. (2007).

Many of the above mentioned medications are prescribed by a general practitioner to treat the resident's medical condition. Do not alter the dose that has been prescribed. You must advise the general practitioner if you think that the medications are causing bladder or bowel problems.

13. Other Resources

The National Continence Helpline
http://www.continence.org.au/helpline.html
Ph 1800 33 00 66

The Continence Foundation of Australia
http://www.continence.org.au/

Alzheimer's Australia
http://www.alzheimers.org.au/

Australian Department of Health and Ageing Bladder and Bowel website
http://www.bladderbowel.gov.au/

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Developed by Deakin University and funded under the National Continence Management Strategy