## Continence Assessment Form and Care Plan

### Best practice recommendations
- Encourage residents to participate as much as possible in toileting activities to remain optimal mobility and independence
- Consider each resident's personal preferences for continence care

<table>
<thead>
<tr>
<th>Assessment Cues</th>
<th>Care Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(tick appropriate response)</strong></td>
<td><strong>(tick appropriate care option)</strong></td>
</tr>
</tbody>
</table>

1. **Does the resident know when to go to the toilet?**
   - Yes
   - Sometimes
   - No

If sometimes or no:
- Identify behaviours showing that the resident may need to go to the toilet (e.g., restlessness)
- List possible cues

   ________________________________________________________________
   ______________________________________________________________________

   □ Supervise  □ Prompt  □ Physically assist the resident to go to the toilet at
   □ fixed times  □ individualised times

2. **Can the resident tell you where the toilet is?**
   - Yes
   - Sometimes
   - No

If sometimes or no:
- Show/remind the resident where the toilet is
- Ensure toilet is easy to identify
- Leave the toilet light on

3. **Can the resident walk to the toilet independently?**
   - Yes, independently
   - Sometimes
   - No, requires supervision
   - No, requires physical assistance
   - No, requires lifting equipment
   - N/A, unable to use toilet

If sometimes or no:
- Place the resident close to the toilets
- Place the following ambulation aids close to the resident
  - Wheely frame
  - Pick up frame
  - Gutter frame
  - Walking stick
  - Wheel chair
  - Other  ________________

   □ Supervise  □ Prompt  □ Physically assist the resident to walk to the toilet

- If physical assistance is required, provide:
  - 1 staff member
  - 2 staff members
  - Lifting equipment
  - Other __________________

4. **Can the resident get on and get off the toilet independently?**
   - Yes, independently
   - Sometimes
   - No, requires supervision
   - No, requires physical assistance
   - No, requires lifting equipment
   - N/A, unable to use toilet

If sometimes or no:
- Encourage the resident to use the following assistive devices
  - Handrails
  - An over the toilet seat frame
  - A donut
  - Other ________________

   □ Supervise  □ Prompt  □ Physically assist the resident to get on and off toilet

- If physical assistance is required, provide:
  - 1 staff member
  - 2 staff members
  - Lifting equipment
  - Other __________________

5. **Can the resident undress and dress themselves before and after toileting?**
   - Yes, independently
   - Sometimes
   - No, requires supervision
   - No, requires physical assistance
   - No, requires lifting equipment
   - N/A, unable to use toilet

If sometimes or no:
- Ensure that the resident has clothing that is easy to manage (i.e., elastic waisted pants with no zips).
- Supervise
- Prompt
- Physically assist the resident to adjust their own clothing.
**SECTION A: Toileting ability, Cognitive skills & Mobility (continued)**

<table>
<thead>
<tr>
<th>Assessment Cues (tick appropriate response)</th>
<th>Care Options (tick appropriate care option)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Can the resident use toilet paper and wipe themselves?</td>
<td>If sometimes or no:</td>
</tr>
<tr>
<td>[ ] Yes, independently</td>
<td>[ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to get toilet paper ready and to use it.</td>
</tr>
<tr>
<td>[ ] Sometimes</td>
<td>[ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to wash their hands at toilet completion.</td>
</tr>
<tr>
<td>[ ] No, requires supervision</td>
<td>[ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to get toilet paper ready and to use it.</td>
</tr>
<tr>
<td>[ ] No, requires physical assistance</td>
<td>[ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to wash their hands at toilet completion.</td>
</tr>
</tbody>
</table>

| 7. Does the resident co-operate with staff when they assist with toileting or changing? | If sometimes or no: |
| [ ] Yes | [ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to get toilet paper ready and to use it. |
| [ ] Sometimes | [ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to wash their hands at toilet completion. |
| [ ] No | [ ] Supervise  [ ] Prompt  [ ] Physically assist the resident to get toilet paper ready and to use it. |

| 8. Does the resident experience pain that restricts their toileting ability? | If sometimes or yes: |
| [ ] Yes | [ ] Check that the resident is getting their pain medication as ordered |
| [ ] Sometimes | [ ] Limit the resident’s movement until pain subsides |
| [ ] No | [ ] Offer bedpans, urinals and/or pads |
| | [ ] If the resident is unable to verbally communicate, search for cues that indicate pain. (List possible cues) ______________________________________________________________ |
| | ______________________________________________________________ |

**SECTION B: Bladder & Bowel pattern**

Refer to 3 day bladder chart and 7 day bowel chart to complete questions

**Best practice recommendations**

- Aim for the resident to be continent and to void 4-6 times a day and no more than 2 times at night
- Aim for the resident to have a regular (at least 3 per week) continent, soft formed stool (i.e. Bristol Stool type 3 or 4 that is easy to pass)
- If the resident has incontinence, aim for them to feel clean and dry with changes of pads soon after each episode
- Assess residents risk for falling if they need to go to the toilet at night

<table>
<thead>
<tr>
<th>Assessment Cues (tick appropriate response)</th>
<th>Care Options (tick appropriate care option)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. During the day, how many times does the resident need to pass urine/go to the toilet on average (from 7am-7pm)?</td>
<td>If less than 3 times, ask the RN, Continence Nurse or GP about the care required.</td>
</tr>
<tr>
<td>[ ] Less than 3 times</td>
<td>If more than 6 times, ask the RN, Continence Nurse or GP about the care required.</td>
</tr>
<tr>
<td>[ ] 4 - 6 times (normal)</td>
<td>[ ] Ensure call bell is within reach.</td>
</tr>
<tr>
<td>[ ] More than 6 times</td>
<td>[ ] Turn night light on.</td>
</tr>
</tbody>
</table>

| 10. During the night, how many times does the resident need to pass urine/go to the toilet on average (from 7pm-7am)? | If once or more: |
| [ ] None | [ ] Ensure commode/pan/toilet is near the bed. |
| [ ] Once | [ ] Turn sensor/s on. |
| [ ] Two or more times | [ ] If resident is awake, offer toileting assistance. |
| | [ ] If the resident passes urine two or more times during the night, ask the RN, Continence Nurse or GP about the care required. |
SECTION B: Bladder & Bowel pattern (continued)

<table>
<thead>
<tr>
<th>Assessment Cues</th>
<th>Care Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>11. Does the resident experience urine leakage during the day?</strong></td>
<td><strong>If yes to urine leakage during the day:</strong></td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ Develop and put in place an individualised toileting program</td>
</tr>
<tr>
<td>□ No</td>
<td>□ Develop and put in place a fixed time toileting program</td>
</tr>
<tr>
<td>If yes, how often?</td>
<td>□ Develop and put in place a pad check and change program</td>
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<tr>
<td>□ Once every few days</td>
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<tr>
<td>□ Once a day</td>
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<tr>
<td>□ Several times a day</td>
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<tr>
<td>□ Most or every time</td>
<td></td>
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</tbody>
</table>

| **12. Does the resident experience urine leakage during the night?** | **If yes to urine leakage during the night:** |
| □ Yes | □ Develop and put in place an individualised toileting program |
| □ No | □ Develop and put in place a fixed time toileting program |
| If yes, how often? | □ Develop and put in place a pad check and change program |
| □ Once every few nights | |
| □ Once a night | |
| □ Several times a night | |
| □ Most or every time | |

| **13. Does the resident have a predictable pattern of passing urine (including urine leakage)?** | **If yes:** |
| a) During the day? | □ Refer to the 3 day bladder chart and use the grid below to mark the times for an individualised toileting program based on the resident's pattern. |
| □ Yes | |
| □ No | |
| b) During the night? | **If no:** |
| □ Yes | □ Use the grid below to mark the times for a fixed time toileting program (i.e. at least every 4 - 6 hours during the day) |
| □ No | □ Use the grid below to mark the times for a pad check and change program (i.e. at least every 4 - 6 hours during the day) |

**Toileting / pad check and change grid (please tick)**

<table>
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<tr>
<th></th>
<th>midnight</th>
<th>1 am</th>
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<th>3 am</th>
<th>4 am</th>
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<th>7 am</th>
<th>8 am</th>
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<th>10 am</th>
<th>11 am</th>
<th>12 noon</th>
<th>1 pm</th>
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<th>3 pm</th>
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<tbody>
<tr>
<td>Toileting times</td>
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<tr>
<td>Pad check &amp; change times</td>
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<td><strong>14. Does the need to pass urine or incontinence at night make it difficult for the resident to go back to sleep?</strong></td>
<td><strong>If sometimes or yes:</strong></td>
</tr>
<tr>
<td>□ N/A</td>
<td>□ Place a commode beside the resident's bed.</td>
</tr>
<tr>
<td>□ No</td>
<td>□ Offer the resident a bedpan or urinal.</td>
</tr>
<tr>
<td>□ Sometimes</td>
<td>□ Identify and put in place individualised strategies to help the resident to return to sleep</td>
</tr>
<tr>
<td>□ Yes</td>
<td></td>
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</tbody>
</table>
### SECTION B: Bladder & Bowel pattern (continued)

<table>
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<tr>
<th>Assessment Cues</th>
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</tr>
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<tbody>
<tr>
<td><strong>15. Does the resident have a urinary catheter in place?</strong></td>
<td><strong>If yes, ask the RN, Continence Nurse or GP about the care required and refer to resident’s catheter care plan.</strong></td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ No assistance required to empty catheter bag</td>
</tr>
<tr>
<td>□ No</td>
<td>□ Supervise the resident to empty catheter bag</td>
</tr>
<tr>
<td>If yes, is the catheter</td>
<td>□ Physically assist the resident to empty catheter bag</td>
</tr>
<tr>
<td>□ Suprapubic?</td>
<td></td>
</tr>
<tr>
<td>□ Urethral?</td>
<td></td>
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</tbody>
</table>

| **16. How often does the resident normally use their bowels?**                | **If less than 3 times per week, or if yes to question 17:** |
| □ Daily to second daily                                                        | **discuss the following options with RN, Continence Nurse or GP**                                                     |
| □ Less than 3 times per week                                                   | □ Increase fluid to __________________________ a day.                                                                  |
|                                                                                  | □ Increase fibre by __________________________.                                                                           |
|                                                                                  | □ Increase mobility (refer to mobility / activity care plan).                                                           |
|                                                                                  | □ Medication (as determined by RN, Continence Nurse or GP).                                                            |
|                                                                                  | □ Refer for further investigation (i.e. Abdominal X-Ray, GUT motility study).                                           |
|                                                                                  | □ Monitor bowel elimination frequency and stool consistency.                                                           |
|                                                                                  | □ Prompt / supervise / assist resident to the toilet at __________________________ each day.                            |
|                                                                                  | □ Encourage the resident to respond to the urge to use their bowels.                                                   |
|                                                                                  | □ Supervise / prompt / assist the resident to sit on the toilet and rest their elbows on their knees with their feet flat on the floor or stool to facilitate bowel emptying. |

| **17. In the past two weeks has the resident leaked, or had accidents or lost control with stool/bowel motion?** | **If yes to any symptom, ask the RN, Continence Nurse or GP about the care required.** |
| □ Yes                                                                           |                                                                                         |
| □ No                                                                           |                                                                                         |

| **18. Has the resident got any of the following symptoms when they use their bowels?** | **If yes to any symptom, ask the RN, Continence Nurse or GP about the care required.** |
| □ Pain and discomfort                                                           |                                                                                         |
| □ Straining                                                                     |                                                                                         |
| □ Bleeding                                                                      |                                                                                         |
| □ Hard, dry motions                                                             |                                                                                         |
| □ Very fluid bowel motions                                                      |                                                                                         |

| **19. Has the resident had a urine test (dipstick) done in the past 28 days?**    | **If the resident’s urine dip-stick shows blood or nitrites or leukocytes or has a pH equal to 8 or above, ask the RN, Continence Nurse or GP about the care required.** |
| □ Yes                                                                           |                                                                                         |
| □ No (this needs to be done)                                                     |                                                                                         |
| pH __________                                                                   |                                                                                         |
| Blood □ Yes □ No                                                                 |                                                                                         |
| Nitrites □ Yes □ No                                                              |                                                                                         |
| Leukocytes □ Yes □ No                                                            |                                                                                         |

**Further comments and/or observations**

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

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### SECTION C: Nutrition (fluid & diet)

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

<table>
<thead>
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</thead>
<tbody>
<tr>
<td><strong>(tick appropriate response)</strong></td>
<td><strong>(tick appropriate care option)</strong></td>
</tr>
<tr>
<td><strong>20.</strong> Does the resident drink an adequate amount of fluid to maintain hydration and healthy bladder and bowel function? <em>(Refer to 3-day bladder chart and check colour of urine)</em></td>
<td>If sometimes or no:</td>
</tr>
<tr>
<td>Yes</td>
<td>Encourage resident to drink ________ cups of __________ per day.</td>
</tr>
<tr>
<td>Sometimes</td>
<td>Monitor and report underhydration (under 5 cups per day &amp; dark coloured urine).</td>
</tr>
<tr>
<td>No</td>
<td>Monitor and report excessive drinking (over 10 cups per day).</td>
</tr>
<tr>
<td><strong>21.</strong> Does the resident eat an adequate amount of food with fibrous content to maintain healthy bladder and bowel function? <em>(Refer to nutritional assessment)</em></td>
<td>If sometimes or no:</td>
</tr>
<tr>
<td>Yes</td>
<td>Refer to resident’s nutritional care plan.</td>
</tr>
<tr>
<td>Sometimes</td>
<td>Encourage the resident to eat cereals, vegetables and fruit regularly.</td>
</tr>
<tr>
<td>No</td>
<td>Offer small snacks regularly.</td>
</tr>
<tr>
<td></td>
<td>Refer to nutritional/swallowing assessment and care plan.</td>
</tr>
<tr>
<td></td>
<td>Ensure dentures are in at meal times and that they fit.</td>
</tr>
</tbody>
</table>

### SECTION D: Skin care

#### Best practice recommendations
- Aim for the resident’s skin to remain intact and free from rashes, excoriation and pressure ulcers

<table>
<thead>
<tr>
<th>Assessment Cues</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>(tick appropriate response)</strong></td>
<td><strong>(tick appropriate care option)</strong></td>
</tr>
<tr>
<td><strong>22.</strong> Does the resident’s skin around their buttocks, groin and perineal area appear to:</td>
<td>If yes to any skin abnormalities, consider the general care options below and ask the RN, Continence Nurse and/or GP about the care required.</td>
</tr>
<tr>
<td>Be very thin or fragile</td>
<td>Change wet pads, linen and clothing soon after incontinent episodes.</td>
</tr>
<tr>
<td>Be reddened</td>
<td>Use the wetness indicators on disposable continence pads as a guide to know when to change the pad.</td>
</tr>
<tr>
<td>Be unusually pale</td>
<td>Use a non-irritating, pH neutral product for washing the skin after each incontinent episode.</td>
</tr>
<tr>
<td>Have a discharge</td>
<td>Use a soft toilet paper or ‘wet ones’ for wiping if skin is very sensitive.</td>
</tr>
<tr>
<td>Have a foul or bad smell</td>
<td>Apply a barrier cream for protection against exposure to urine and/or faeces</td>
</tr>
<tr>
<td>Be broken, have a rash or have lumps and blotches</td>
<td>Other (specify) ________________</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

| 23. Is the resident currently using a continence product to contain their incontinence? | Select from the following options: |
| Yes – during day and night | Disposable pad (type) _______ |
| Yes – during day only | Disposable pad (type) ________ |
| Yes – during night only | Disposable pad (type) ________ |
| No | Disposable pad (type) ________ |
| | Washable pad/pant (type) _________ |
| | Commode (type) ________ |
| | Condom drainage (type) ________ |

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SECTION E: Medical
(This section may need to be completed by an RN, Continence Nurse or GP)

24. Please indicate whether or not the resident has any of the following potentially reversible causes of incontinence

☐ Delirium  ☐ Bladder infection  ☐ Constipation  ☐ Irritable bowel syndrome  ☐ Medication
☐ Atrophic vaginitis  ☐ Unstable diabetes  ☐ Depression  ☐ Enlarged prostate  ☐ Restraint use

25. If yes to any of the conditions, could this condition be causing the resident's incontinence?

☐ No
☐ Yes (please list) __________________________________________________________________________

26. Is there any potential to treat or improve the residents' condition with any of the following options

☐ Medication  ☐ Bladder training  ☐ Electrical stimulation  ☐ Pelvic floor muscle training program
☐ Referral to:  ☐ GP  ☐ Continence Nurse  ☐ Urologist  ☐ Geriatrician  ☐ Gynaecologist  ☐ Physiotherapist

SECTION F: Resident Perspectives
(This section should be completed in conjunction with residents and/or their family members)

Best practice recommendations
- Ensure residents and families are given information about healthy bladder and bowel habits.
- If the resident has a low affect and/or is bothered by their symptoms discuss this with an RN or the GP.
- If a continence product is used, ensure that it fits the resident, absorbs any incontinence, and protects the resident's underwear and outer clothing.

Bladder Function

27. If you are experiencing a bladder problem, what kind of assistance would you prefer? (may tick more than one)

☐ No assistance
☐ To be assisted to go to the toilet at _____________________
☐ To wear pads during the day
☐ To wear pads during the night
☐ To be seen by a specialist for further investigation
☐ Other ____________________________________________________________________________________

28. If you are experiencing a bowel problem, what kind of assistance would you prefer? (may tick more than one)

☐ 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
☐ To be seen by a specialist for further investigation
☐ Other ____________________________________________________________________________________

29. If you are experiencing a bladder problem, how much of a problem is this for you?

☐ No problem  ☐ A bit of a problem  ☐ Quite a problem  ☐ Severe problem

30. If you are experiencing a bowel problem, how much of a problem is this for you?

☐ No problem  ☐ A bit of a problem  ☐ Quite a problem  ☐ Severe problem

31. If you are wearing a continence product, does it keep you dry and comfortable?

☐ N/A  ☐ Yes  ☐ No

If no, would you like to consider other options?

☐ Yes  ☐ No

Further comments and/or observations __________________________________________________________

Staff member completing assessment

Name _____________________________________
Signature ________________________________
Designation ________________ Date __________

Staff member endorsing this assessment

Name _____________________________________
Signature ________________________________
Designation ________________ Date __________

Care plan discussed with and agreed to by family

☐ Yes  ☐ No  ☐ N/A

Family/Other – Name __________________________
Signature ________________________________
Relationship ______________________________ Date __________

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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 [ ] No [ ] Other
- Wandering [ ] No [ ] Other
- Pulls at clothes [ ] No [ ] Other

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

<table>
<thead>
<tr>
<th>Time</th>
<th>7am</th>
<th>8am</th>
<th>9am</th>
<th>10am</th>
<th>11am</th>
<th>noon</th>
<th>1pm</th>
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<th>4pm</th>
<th>5pm</th>
<th>6pm</th>
<th>7pm</th>
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<tbody>
<tr>
<td>Toileting times</td>
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<td>Pad check &amp; change times</td>
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5. Resident’s night time toileting / pad check & change program

<table>
<thead>
<tr>
<th>Time</th>
<th>7pm</th>
<th>8pm</th>
<th>9pm</th>
<th>10pm</th>
<th>11pm</th>
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<td>Toileting times</td>
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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 ____________________
- To wear pads (specify type) ____________________
- Other ____________________

b) During the night
- No assistance
- Assistance to go to the toilet at ____________________
- 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 ____________________

Continence Care Summary

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