ALL WALES CONTINENCE RISK ASSESSMENT

NHS Wales v1.2 (04/10/2024)

ADDRESSOGRAPH

Continence Risk Initial Assessment to be completed within 4 hours of admission.
A review to be undertaken on each transfer to a Clinical Area/Ward.

If continence / toileting needs are identified the patient must be re-assessed at least **weekly** or sooner if their condition changes and their care plan updated accordingly.

If answered **YES** to **any** question(s) the patient is at High Risk of becoming incontinent or may already be experiencing incontinence. If risk identified implement an individual **Treatment / Toileting or Management Care Plan.**

Continence status, needs and preferences must be discussed and confirmed at each nursing handover.

Hospital														
Ward														
Date	DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY		DD/MM/YY	
Time	HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM		HH:MM	
At this CURRENT time does your patient:														
Need help to get to the toilet	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have any cognitive problems	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have mobility problems	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to rush to the toilet	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Need to use the toilet frequently	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Leak urine?	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No
If **Yes**, (tick): Occasionally														
Regularly														
Leak faeces?	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No
If **Yes**, (tick): Occasionally														
Regularly														
Have constipation?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have diarrhoea?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Bristol stool type?														
Have difficulty passing urine?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Have difficulty passing faeces?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally wear a pad or use other devices?	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Normally use a catheter?	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No	**Yes**	No
If **Yes**, (tick): Indwelling														
Intermittent Self Catheterisation														
Normally use any equipment to help with toileting	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Name (Print & Signature)														
Designation														