



National Audit of Continence Care 2010

Clinical Proforma for Bladder Problems – Urinary Incontinence

Please answer ALL questions (one proforma to be completed per patient/resident)

Your Site Code

MEN ONLY

Instructions for completion:

1. Please use a ball-point pen for all sections.
 2. Please cross the boxes as appropriate (☒ or ☒).
- If you are unclear of any questions on this form please use the accompanying *help booklet*.

All enquires should be sent, quoting your site code, to:

Tel: 020 3075 1347 / 020 3075 1619 / 020 3075 1511 or e-mail: nacc@rcplondon.ac.uk

AUDITOR DISCIPLINE

Select main discipline for this case:

Doctor Nurse Therapist Manager

Other

DEMOGRAPHIC INFORMATION

A. Patient audit number

B. Age (Years)

C. Sex

Male Female

D. Ethnicity:

White British Other Not recorded

E. Is English the primary language of the patient?

Yes No
 Not known Not documented

F. Please indicate in which care setting this patient is in? (choose one only)

Care home (residential and nursing)

Patient of local continence service

Community dwelling in-patient

other (please specify):

In-patient of primary care trust run hospital

Patient of acute trust hospital

1. SYMPTOMS

1.1 Does the patient have: (please answer all questions)		Condition documented as:			
		Present	Absent	Not documented	Records not available on site
1.1i	Nocturnal frequency (>2 voids /night)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1ii	Urinary frequency (>8 voids/24h)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1iii	Nocturnal enuresis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1iv	Urinary urgency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1v	Urgency (urge) incontinence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1vi	Stress urinary incontinence (urine loss with coughing, straining, exertion)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1vii	Post micturition dribble	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1viii	Clinically significant post void residual volume	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1ix	Voiding difficulty	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1x	Intermittent catheter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1xi	Permanent catheter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1xii	Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
1.1xiii	Bladder pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

1.2 What other relevant documented conditions does the patient have either currently or in the past? (select all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Bladder cancer/stones | <input type="checkbox"/> Prostate disease or surgery |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Recurrent falls |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Spinal cord disease/trauma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Faecal loading or chronic constipation | |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Acute urinary tract infection |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Impaired mobility | <input type="checkbox"/> <input style="width: 200px; height: 20px;" type="text"/> |
| <input type="checkbox"/> Neurological disease | |
| <input type="checkbox"/> Obesity | |
| <input type="checkbox"/> Pelvic radiotherapy | |
| | <input type="checkbox"/> No documentation of the above |

1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence?
(select all that apply) (See help notes for guidance)

- | | |
|--|--|
| <input type="checkbox"/> Stress urinary incontinence | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Mixed urinary incontinence | <input type="checkbox"/> Voiding difficulty |
| <input type="checkbox"/> Passive leakage | |
| <input type="checkbox"/> Urgency urinary Incontinence | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Detrusor overactivity /
overactive bladder | <input type="checkbox"/> |
| <input type="checkbox"/> Functional (see help notes) | <input type="checkbox"/> No diagnosis documented |

Cognitive status

- 1.4 Has the patient's cognition been assessed?
(see help notes for guidance) Yes No Not documented
(If YES answer ALL / If NO or Not documented answer 1.4i and proceed to 1.5)
- 1.4i Is the patient's cognitive status:
(see help notes for guidance) Unimpaired Mild Moderate Severe
 Insufficient information to calculate
- 1.4ii Is there documented use of a formal scoring system for assessment of cognition?
(see help notes for guidance) Yes No

Functional status

- 1.5 Has the patient's functional ability been assessed?
(see help notes for guidance) Yes No Not documented
(If YES answer ALL / If NO or Not documented answer 1.5i and proceed to 2)
- 1.5i Is the patient's functional status:
(see help notes for guidance) Unimpaired Mild Moderate Severe
 Insufficient information to calculate
- 1.5ii Is there documented use of a formal scoring system for assessment of functional ability?
(see help notes for guidance) Yes No

2. ASSESSMENT, EXAMINATION AND INVESTIGATIONS

ASSESSMENT

History

- 2.1 Is there documented evidence of a continence history? Yes No *(if NO go to 2.2)*
- 2.1i **If yes**, does the history of urinary incontinence include:
Daytime symptoms Yes No Not documented Records not available on site
Nocturnal symptoms Yes No Not documented Records not available on site
- 2.2 Is the patient incontinent of faeces? Yes No
- 2.3 Is the patient's bowel habit documented? Yes No
- 2.5 Is there documented evidence of the use of any bladder diary? Yes No **No, but** the patient is incompetent to use a chart/diary
- 2.6 Is the patient on medication that may exacerbate urinary incontinence? Yes No *(if NO go to 2.7)*
- 2.6i Has this medication been altered to minimise its impact? Yes No Not able to minimise further

- 2.7 Is there documented evidence that the impact of symptoms on quality of life has been assessed? Yes No **No, but** patient is mentally incompetent to undergo assessment
- 2.9 Is there evidence of the use of a validated symptom score at initial assessment? Yes No **No, but** patient is mentally incompetent to undergo assessment

EXAMINATION

Basic examination

(for guidance on what constitutes “basic examination” see help notes)

- 2.10 Is there a documented indication for rectal examination? (select all that apply) Assessment of prostate size
 Constipation
 Voiding difficulty
 Retention of urine
 Not documented
- 2.11 Is there documented evidence that a rectal examination was performed? Yes No, **No, but** consent could not be gained
- 2.12 Is there documented evidence of urinalysis? Yes No
- 2.13 Is there documented evidence of a mid stream specimen of urine being sent? Yes No **No, but** patient is distressed or too agitated?

Focused examination

(for guidance on what constitutes a “focused examination” see help notes)

- 2.14 Is there documented evidence that a focused examination has been performed? Yes No (if **NO** go to 2.15)
- 2.14i **If yes**, who has performed the examination? (Select all that apply)

- | | |
|------------------------------------|--|
| <input type="radio"/> Geriatrician | <input type="radio"/> Therapist |
| <input type="radio"/> GP | <input type="radio"/> Hospital ward based doctor |
| <input type="radio"/> Nurse | <input type="radio"/> Urologist |
| | <input type="radio"/> Other (please specify) |

- 2.15 Is there documented evidence of the following?
- 2.15i Examination of the abdomen for palpable mass or bladder retention Yes No
- 2.15ii Examination to assess pelvic floor dysfunction Yes No
- 2.15iv Rectal examination to exclude faecal loading/prostate size Yes No **No, but** consent could not be gained

INVESTIGATIONS

Initial Assessment

- 2.17 Is there documented evidence of:
(select all that apply)
- | | |
|---|--|
| <input type="checkbox"/> Urea & Electrolytes | <input type="checkbox"/> Abdominal X-ray |
| <input type="checkbox"/> GFR (without indication of renal impairment) | <input type="checkbox"/> Flow Rate |
| <input type="checkbox"/> Cystoscopy | <input type="checkbox"/> Post void residual volume |
| <input type="checkbox"/> Abdominal Ultrasound | <input type="checkbox"/> None of the above |
- 2.19 Is there documented evidence of the use of a pad test for routine assessment? Yes No

Specialised Assessment

- 2.20 Is there documented evidence of:
- | | |
|---|--|
| <input type="checkbox"/> Cystoscopy for men with chronic retention, pain or recurrent urinary infection | <input type="checkbox"/> Post void residual volume |
| <input type="checkbox"/> Flow Rate | <input type="checkbox"/> None of the above |
- 2.21 Is there documented use of routine imaging (CT / MRI / X-ray / ultrasound) for routine assessment? Yes No Records not available on site

URODYNAMIC TESTING (CYSTOMETRY)

- 2.23 Did the patient have conservative treatment? Yes No Records not available on site
If no go to 2.25 if yes go to 2.24
- 2.24 Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment? **(see help notes for guidance)** Yes No Records not available on site
 Not documented
- 2.25 Did the patient have surgery or is it documented that they are considering surgery? Yes No Records not available on site
If YES go to 2.7 / If NO go to 2.28
- 2.27 Is there documented evidence of multi channel cystometry for men considering surgery for their lower urinary tract symptoms (LUTS)? Yes No Records not available on site
 Patient not considering surgery

Diagnosis

- 2.28 Is there documented evidence of a clear identification of the type/cause of urinary incontinence? Yes No

3. MANAGEMENT

Treatment

3.1 Did the patient require treatment? Yes No

3.2 Did the patient have a treatment plan? Yes No

If you answered 'NO' to both 3.1 & 3.2 go to 3.4 otherwise answer 3.3

3.3 Which of the following methods of treatment have been used or are planned?

(select all that apply)

	Used	Planned	Neither Used or Planned	
3.3i	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifestyle modification
3.3ii	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioural modification
3.3iii	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bladder training regimes (supervised)
3.3iv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Containment
3.3v	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Electrical stimulation (incl. afferent nerve stimulation)
3.3vi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Management of faecal impaction
3.3viii	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic floor training (supervised and of minimum three months duration)
3.3ix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Review of medication
3.3x	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toileting schedules
3.3xi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment of co-morbidities
3.3xii	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Treatment of acute urinary tract infection
3.3xiii	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urethral milking
3.3xiv	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)

Pharmacological interventions

3.4 Is there documented evidence of the use of anti-muscarinic medication for the treatment of Over Active Bladder (OAB)? Yes No Did not have OAB

3.5 Is there documented evidence of a late afternoon diuretic for men with nocturnal polyuria? Yes No Did not have nocturnal polyuria

If answer is 'Did not have...' go to 3.7

3.6 Is there documented use of DDAVP for men with nocturnal polyuria who have not benefited from other treatments? Yes No Did not have nocturnal polyuria

3.7 Is there documented use of alpha blockers for treatment of men with moderate to severe LUTS? Yes No Did not have moderate to severe LUTS

If answer is 'NO' or 'Did not...' Do not answer 3.9

3.8 Is there documented use of 5-AR to men with larger prostates (30ml, or PSA >1.4ng/ml) considered to be at high risk of progression? Yes No Did not have large prostate (30ml, or PSA >1.4ng/ml)

3.9 Is there evidence of an anticholinergic being added for men with persisting storage symptoms despite treatment with alpha blockers? Yes No Did not have storage problems

Yes but, patient did not have alpha blockers first.

Surgery

- 3.13 For men, did the patient consider or have surgical intervention for LUTS secondary to benign prostatic enlargement? Yes No Records not available on site
(If YES go to 3.13i if NO go to 3.15)
- 3.13i Is there documented evidence of the following procedures being carried out:
(select all that apply)
- Transurethral resection of the prostate (TURP)
 - Holmium laser enucleation of the prostate (HOLEP) (only at specialist centre)
 - Transurethral incision of the prostate (TUIP)(only in men with a small prostate)
 - Open prostatectomy (OP) (only in men with a large prostate)
 - Transurethral needle ablation (TUNA)
 - Transurethral microwave thermotherapy (TUMT)
 - High intensity focused ultrasound (HIFU)
 - Transurethral ethanol ablation of the prostate (TEAP)
 - Transurethral vaporization resection of the prostate (TURVP)
 - None of the above

CONTAINMENT

- 3.15 Which of the following methods of containment have been used or are planned for treatment?
(select all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Body worn pads (disposable) | <input type="checkbox"/> Intermittent catheterisation |
| <input type="checkbox"/> Body worn pads (re-usable) | <input type="checkbox"/> Devices (see help notes for guidance) |
| <input type="checkbox"/> All-in-one disposable | <input type="checkbox"/> Penile Clamps |
| <input type="checkbox"/> All-in-one (re-usable) | <input type="checkbox"/> Containment not part of care plan |
| <input type="checkbox"/> Reusable products (pants) | <input type="checkbox"/> Not documented |
| <input type="checkbox"/> Bed protection | <input type="checkbox"/> Other (please specify) |
| <input type="checkbox"/> Indwelling catheter | <input type="text"/> |
- 3.16 Is there documented evidence of the indication for indwelling catheterisation as a form of management? Yes No
- 3.17 Is there documented evidence of the arrangement for provision of maintenance products on discharge from hospital? Yes No Not applicable
(Hospitalised patients only)
- 3.17i **Is this: (choose one only)**
- Patient to buy products
 - Limited supply from hospital followed by own supply
 - Limited supply from hospital followed by NHS supply
 - No supply from hospital with an arrangement for NHS supply

4. CARE PLAN / REVIEW / COMMUNICATION

- 4.1 Does the patient have a documented continence care plan? Yes No *(if NO go to 4.2)*
- 4.1i **If yes**, when was the patient's care plan last reviewed?
- Less than 6 months
 6-8 months
 9-11 months
 12 months or more
 No documentation of reassessment
- 4.2 Is there evidence of a review for men on alpha blockers at:
- 4-6 weeks Yes No Not on alpha blockers
 Not yet relevant
- Then 6-12 months Yes No Not on alpha blockers
 Not yet relevant
- 4.3 Is there evidence of a review for men on 5-AR therapy at:
- 3-6 months Yes No Not on 5-AR therapy
 Not yet relevant
- Then 6-12 months Yes No Not on 5-AR therapy
 Not yet relevant
- 4.4 Is there evidence of a review for men on anti-cholinergics at:
- 4-6 weeks Yes No Not on anti-cholinergics
 Not yet relevant
- Then 6-12 months Yes No Not on anti-cholinergics
 Not yet relevant
- 4.5 Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient? Yes No **No, but** the patient lacks mental capacity.
- 4.6 Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? Yes No **No, but** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.

COMMUNICATION / INFORMATION

- 4.7 Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence? Yes No **No, but** the patient is incompetent to participate in such discussion
- 4.8 Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? Yes No **No, but** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.