Queensland Health

# Clinical Task Instruction

Skill Shared Task

# S-AD04: Assess toileting and provide basic/bridging intervention

## Scope and objectives of clinical task

This CTI will enable the health professional to:

- assess the client's ability to recognise the need to void, including planning, monitoring and managing voiding/emptying.


**VERSION CONTROL**

| | | | |
|---|---|---|---|
| Version: | 1.1 | | |
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The CTI reflects best practice and agreed process for conduct of the task at the time of approval and should not be altered. Feedback, including proposed amendments to this published document, should be directed to AHPOQ at: allied_health_advisory@health.qld.gov.au.

This CTI must be used under a skill sharing framework implemented at the work unit level. The framework is available at: https://www.health.qld.gov.au/ahwac/html/calderdale-framework.asp

Please check https://www.health.qld.gov.au/ahwac/html/clintaskinstructions.asp for the latest version of this CTI.

- assess the client's ability to safely and effectively perform toileting, including mobilising to the toilet, transferring on/off the toilet, sitting on the toilet, adjusting clothing and continence products (if relevant), and performing hygiene e.g. shake/wipe, clean hands, removal of waste.
- develop and implement an appropriate plan to address identified toileting problems, including providing standard education on compensatory strategies and equipment i.e. use of wipes, long handled wipers, modified clothing, urinal bottle and access to continence products (pads).

# Requisite training, knowledge, skills and experience

## Training

- Mandatory training requirements relevant to Queensland Health/Hospital and Health Service (HHS) clinical roles are assumed knowledge for this CTI.
- If not part of mandatory training requirements, complete patient manual handling techniques, including the use of walk belts and sit to stand transfers.
- Competence in or demonstrated professional equivalence in:
  - CTI S-AD05: Prescribe, train and review use of toilet seating equipment. S-AD05 provides competence in examining toilet seating equipment and should be completed concurrently with S-AD04 if the skill share-trained health professional will implement S-AD04 with clients that use prescribed toilet seating. The health professional can implement S-AD04 with the toilet seating equipment they have demonstrated competence in S-AD05
  - CTI S-MT01: Assess functional walking
  - CTI S-MT07: Assess standing transfer

  and if the use of walking aids is within the scope of the local implementation:
  - CTI S-MT02: Prescribe, train and review of walking aids.
- If the local service implementation includes performing the task in the community setting additional training may also be required e.g. driver safety, workplace procedures for home visiting, occupational violence prevention and management. Additional training should be listed in the Performance Criteria Checklist or included in orientation checklists and/or workplace instructions.

## Clinical knowledge

- To deliver this clinical task a health professional is required to possess the following theoretical knowledge:
  - understand and identify from the medical record and client observation common conditions (physical and cognitive) that make toileting difficult.
  - impacts of toileting problems e.g. risk of infection, psychological (dignity, modesty, cultural).
  - usual patterns of toileting and common variances e.g. pedestal/squat toilets, off the shelf continence products, toileting regime, use of a bidet, urinal bottle or bedpan, catheter or colostomy.
  - elements of safe, hygienic, effective toileting, including seating factors that impact voiding e.g. planning, sitting balance and posture, upper limb/trunk range of motion, sensation and timing.
  - potential causes of toileting problems and common compensatory strategies including adaptive clothing and techniques, use of hand wipes, environmental set-up and continence products.

  - local processes/protocols/funding scheme requirements for continence products e.g. Department of Veterans' Affairs (DVA), Medical Aids Subsidy Scheme (MASS), National Disability Insurance Scheme (NDIS).
- The knowledge requirements will be met by the following activities:
  - review of the Learning resource.
  - receive instruction from the lead health professional in the training phase.

## Skills or experience

- The following skills or experience are not specifically identified in the task procedure but support the safe and effective performance of the task or the efficiency of the training process and are:
  - **required** by a health professional in order to deliver this task:
    - nil.
  - **relevant but not mandatory** for a health professional to possess in order to deliver this task:
    - experience providing continence education and/or prescription of continence products.
    - competence in prescribing, training in the use of and reviewing bathroom grab rails and/or showering equipment.
    - competence in dressing assessment.

# Indications and limitations for use of a skill shared task

The skill share-trained health professional shall use their independent clinical judgement to determine the situations in which they will deliver this clinical task. The following recommended indications and limitations are provided as a guide to the use of the CTI, but the health professional is responsible for applying clinical reasoning and understanding of the potential risks and benefits of providing the task in each clinical situation.

## Indications

- The client has been identified as having problems toileting. This may be via referral, subjective history or direct observation e.g. evidence of incontinence, difficulty pulling clothing and/or underwear up/down, wiping self or reported falls in the toilet/bathroom.
- The client is medically stable and there is no medical prohibition to participating in a toileting assessment e.g. the medical record indicates that the client can access the toilet, vital signs are within expected limits or the client is living in the community and is not acutely unwell.

## Limitations

- Limitations listed in CTI S-AD05, CTI S-MT01, CTI S-MT07 apply. If walking aids are used, the limitations in CTI S-MT02 apply.
- If the skill share-trained health professional was not required to complete the CTIs, as they are within the existing expertise and scope of practice then:
  - review the limitations in the CTIs listed above as part of the training process.
  - consider existing skills, knowledge and experience in the tasks.

  - in collaboration with the lead health professional, determine and document bespoke limitations to this task relevant to the individual's scope of practice.

For example, teams may determine that physiotherapists with task expertise in walking and transfer assessments may include client groups in the scope of this CTI that would be otherwise excluded e.g. clients with amputations or clients that are non-weight bearing.

- Additional limitations include:
  - the client is known to require full assistance for toileting or currently uses prescribed continence products (liners, pull ups) for all toileting activities and there has been no change in physical or cognitive function to indicate a need for re-assessment.
  - the client is unable to sit upright without support and/or demonstrates poor dynamic sitting balance. At a minimum, the client should be observed to be able to maintain sitting balance when reaching behind, leaning to the side and reaching towards the ground.
  - the client requires more than one light assist to transfer, has a lower limb amputation, weight bearing restriction or uses a hoist or a method of transfer for which the skill share-trained health professional has not been trained and assessed as competent.
  - the client uses a mobility aid for which the skill share-trained health professional has not been trained to supervise and assessed as competent e.g. wheelchair, scooter, walking aid.
  - the client has a new visual or perceptual deficit, including no vision or hemianopia. At a minimum, the client must be able to see their hand in front of their face or demonstrate effective use of compensatory strategies e.g. use of glasses, contrasting colours or scanning to the other side for visual neglect.
  - the client has a significant cognitive deficit. At a minimum, the client must be able to follow simple instructions for safety.
  - the client has transient, limited or reduced sensation to the perineum and/or hand e.g. spinal cord compression/injury, peripheral neuropathy or neurological disease.
  - the client has been referred for assessment and/or education of toileting position to improve constipation i.e. sitting with feet placed on foot stool. The client should be reviewed by a health professional with expertise in pelvic floor training programs e.g. physiotherapist, occupational therapist or continence nurse.
  - the client has a stoma or suprapubic catheter. A client with a stoma will need to access the toilet for voiding urine. A client with a suprapubic catheter will access the toilet for their bowels. If a client has both, they will not use a toilet. The assessment should be adapted for the client's requirements, including any regimes for managing the stoma or suprapubic catheter effectively. The skill share-trained health professional should liaise with a health professional with expertise in catheter and/or stoma management as part of the task.
  - the client's preferred hygiene method is to use a bidet. Additional skills and knowledge are required to assess use of a bidet. The local service should determine if this is in scope for the skill share-trained professional and consider additional training requirements.
  - the client reports significant concerns and/or anxiety with being assessed during toileting or does not consent to be being observed during toileting. This may be due to modesty concerns and/or gender of the health professional performing the task. Discuss the concerns with the client including the purpose of the task. Determine if the client is happy to proceed in a simulated environment or with another health professional.

# Safety and quality

## Client

- The skill share-trained health professional shall identify and monitor the following risks and precautions that are specifically relevant to this clinical task:
  - orthopaedic, surgical or medical restrictions will be documented via protocols, theatre notes, or medical orders e.g. weight bearing status (non, touch, partial, full), total hip replacement precautions, mobilise within range of a movement brace only, sternotomy precautions for upper limb weight bearing, history of shoulder dislocation or surgery. The client with restrictions must be cleared to undertake the task by the medical team or through a protocol/care pathway and any restrictions must be adhered to during the task. If restrictions are unable to be maintained during the task, it should be ceased. If restrictions are unclear, consult with the treating team.
  - as toileting requires good dynamic balance, stand-by assistance of the client is required at all times. If the client needs to void, privacy should be provided without compromising safety e.g. client holds grab rail during voiding whilst the skill share-trained professional stands outside the door and the client waits for stand-by assistance prior to attending to perineal hygiene.
  - if the client is at risk of pressure injury or skin shearing, include frequent visual inspection during the task. Increased risk occurs if the client has frail skin or is malnourished, incontinent or has limited mobility. If injury occurs, cease the task and inform the treating team of any new wounds. If the client has an existing pressure area/skin tear, ensure the wound is covered with a dressing prior to commencing the task. If the injury is to be in contact with the seating surface, liaise with the medical team regarding any limitations to sitting duration and monitor the client's pain. Cease the task if limits are exceeded.
  - shoes should be worn. Shoes should be enclosed, well-fitting and have good traction. If in the client's home, conduct the assessment with the client's usual footwear e.g. slippers, socks or bare feet. This should be noted in the chart entry with any recommendations for safety e.g. replace slippers.

## Equipment, aids and appliances

- The client should be assessed using their usual toileting aids and/or appliances. If their usual aid/appliance is not available, a similar trial/loan should be provided. Note: if the client has new restrictions equipment should be introduced to support maintenance of restrictions e.g. over toilet frame.
- Perform an equipment safety check ensuring that the safe working load is suitable for the client, the height is adjusted to meet any restrictions/functional requirements and the dimensions accommodate the client's body shape without skin shearing. The safe working load for toilet seating equipment is generally 110-125kg. Clients above this weight range should be considered for bariatric equipment.
- Ensure all equipment is clean and in good working order as per local infection control protocols. Refer to the manufacturer's guidelines for specific maintenance requirements e.g. check rubber grips have not perished and rubber stoppers are in place and have tread.
- As the client may require assistance to complete the task, it is advisable to either wear gloves or have them readily available. Cleaning equipment and products should also be readily available in case of spillage.

## Environment

- Privacy should be maintained to ensure client modesty e.g. door closed, curtain pulled.
- If the task is being undertaken in a ward, check the toilet environment for circulation space. Remove excess or unnecessary equipment prior to the client accessing the toileting area.
- If the task is being undertaken in the client's home, a visual safety inspection of the toilet environment should be conducted prior to the task including checking there are no leaks, cracks or loosening to the cistern, pedestal or floor surface. If an issue is identified, the client and/or carer should be informed of the required maintenance and any local service protocols implemented e.g. falls prevention or public housing notifications. Alternative equipment may be required for use whilst repairs are undertaken e.g. commode chair.

# Performance of clinical task

## 1. Preparation

- Use information collected from the medical chart to determine the client's toileting ability including the use of any modified techniques and/or aids, required assistance, and that the client has no medical prohibitions to undertaking the task as per the Guide to conducting a toileting history in the Learning resource.
- Ensure the client has any required equipment available in the toilet room such as an over toilet frame, raised toilet seat and any aids/products e.g. bottom wiper, continence products or flushable wipes.

## 2. Introduce task and seek consent

- The health professional checks three forms of client identification: full name, date of birth, **plus one** of the following: hospital unit record (UR) number, Medicare number, or address.
- The health professional introduces the task and seeks informed consent according to the Queensland Health Guide to Informed Decision-making in Health Care, 2nd edition (2017).
- As the task involves observation of toileting, client consent should include information on the need to be observed and details on how privacy and dignity will be maintained.

## 3. Positioning

- The client's position during the task should be:
  - standing initially to mobilise into the toilet, turning, sitting down and standing up as part of the assessment process.
- The health professional's position during the task should be:
  - standing in a position that allows observation of the task and stand-by assistance for safety.

## 4. Task procedure

- The task comprises the following steps:
  1. Explain and demonstrate (where applicable) the task to the client.
  2. Check the client has understood the task and provide an opportunity to ask questions.
  3. Obtain or confirm information from the client (or carer) with regard to:

a. current physical capability/issues in relation to toileting e.g. equipment requirements, personal preferences and problems or concerns
b. ability to sit and stand including balance e.g. falls history, confidence sitting, standing or mobilising, assistance required, aid used and medical/surgical restrictions
c. continence history.

See the *Guide to conducting a toileting history* in the Learning resource and the Indications and limitations section.

On the basis of the information obtained, determine if the task will progress to include observation of toileting performance.

4. Observe the client in sitting. Assess the client's static and dynamic balance. If the client has poor sitting balance, cease the task (see the Limitations section). Document observations and liaise with a health professional with expertise in toileting assessment to develop a management plan.
5. Observe the client's performance of standing up from sitting. If required, provide assistance as per the local health service patient manual handling protocol. If the client requires more than light assistance, cease the task and ask the client to sit back down. Document the outcome and liaise with a health professional with expertise in toileting assessment to develop a management plan.
6. Ask the client to mobilise to the toilet using their usual mobility aid/s (if relevant). Assess the client's ability to locate the toilet, open/close the toilet door and negotiate the doorway threshold. If required, provide assistance using cueing and/or manual guidance/assistance as per the local health service patient manual handling protocol.
7. Ask the client to demonstrate how they use the toilet. Assess performance including transfer on/off the toilet, clothing management and hygiene, see *Table 1: Clinical reasoning guide to observing toileting performance* in the Learning resource. Note verbal prompting, physical assistance and/or compensatory strategies required to complete the task.

   Note 1: If the client does not need to void or open their bowels, have the client demonstrate/simulate all aspects of the task as per *Table 1: Clinical reasoning guide to observing toileting performance* in the Learning resource.

   Note 2: If the client wears continence products, observe the client replacing the product as part of the assessment process noting planning, physical requirements/capability and outcome of the task.
8. Determine if the client would benefit from a basic/bridging intervention/s to improve toileting performance. Refer to Table 1: *Clinical reasoning guide to observing toileting performance* in the Learning resource.
9. Select appropriate basic/bridging intervention/s considering the client's goals, impact on independence, safety and timeliness of task performance.
10. Discuss and develop a plan with the client and/or carer (if relevant) for intervention/s i.e. environmental set-up, one-handed techniques and/or toileting equipment. If recommending equipment, include features, maintenance requirements, risks, costs and proposed benefits for independence.
11. Implement the plan by providing education, including demonstration (if required), for each intervention. Observe the client using the prescribed technique/equipment. Provide cueing and manual guidance if required for safety and training effectiveness. Make any adjustments to the plan to improve performance.
12. Determine if the client requires further review and/or rehabilitation.

## 5. Monitoring performance and tolerance during the task

- Common errors and compensation strategies to be monitored and corrected during task include:
  - the client does not complete the task in a usual toileting order e.g. does not pull underwear down before voiding, wipes self after pulling underwear up. Provide the client an opportunity to self-correct. If the client does not self-correct, verbally prompt the client to the correct order and then if required, provide manual guidance or physical assistance.
  - the client has difficulty orientating clothing and/or continence products (if relevant) e.g. front to back or inside out. Provide the client an opportunity to self-correct. If the client does not self-correct, verbally prompt the client to the correct order and then if required, provide manual guidance or physical assistance.
  - zippers, buttons, belts and/or ties are not fastened. Provide the client an opportunity to self-correct. If the client does not self-correct, prompt the client to the correct order and then provide assistance.
  - the client does not complete perineal hygiene or hand washing. Determine if this is an infection risk to the client or others. If yes, provide a verbal prompt and/or assistance to complete.
  - if the client wears continence products, observe if they are excessively soiled/wet and changed correctly. If not replaced correctly, provide the client an opportunity to self-correct. If the client does not self-correct, verbally prompt the client to the correct process and then if required, provide manual guidance or physical assistance.
- Monitor for adverse reactions and implement appropriate mitigation strategies as outlined in the Safety and quality section above.

## 6. Progression

- The client may require further assessment of toileting if goals or factors impacting toileting change e.g. the client has a suprapubic catheter inserted or starts using continence products, there is a change in medical or surgical restrictions, a new fall, the client moves residence, there is a change in assistance available, or the client has an acute injury to the limbs, hospital admission, illness or surgery.

## 7. Document

- Document the outcomes of the task as part of the skill share-trained health professional's entry in the relevant clinical record, consistent with relevant documentation standards and local procedures, and commenting on the client's ability to complete the task including the following specifics of the task performance:
  - the environment the task was undertaken e.g. hospital ward bathroom or client's ensuite
  - the ability to initiate and complete the task in a timely manner
  - the ability to plan the task including the correct use of required equipment e.g. mobility aid, continence products, wipes, long handled wiper, toilet seating equipment or grab rails
  - if using a mobility aid, the ability to safely use the brakes (if relevant) and manoeuvre within the environment
  - the ability to adjust and orientate clothing and continence products (if relevant)
  - observed sequence for toileting

  - management of waste product/materials e.g. able to flush the toilet or has a plan and process in place for the removal of the commode pan or continence products
  - safety during the task and the client's awareness of potential dangers
  - aspects of the task that required the use of redirection/verbal cueing, manual guidance or physical assistance e.g. clothing adjustment, wiping, manoeuvring mobility aid or removal of waste
  - a recommendation for ongoing toileting performance e.g. independent, requires equipment, assistance. If assistance is required, this should be described e.g. cueing, manual guidance, environmental set-up or symptom monitoring
  - if equipment and/or a rehabilitation goal is developed record the goal and plan to achieve it e.g. standard education on compensatory strategies and equipment such as the use of wipes, long handled wipers, modified clothing, urinal bottle, access to continence products (pads) or referral for comprehensive rehabilitation program
  - any basic/bridging interventions that were provided as part of the session including the outcome for each intervention i.e. change in performance and recommendation for ongoing use.
- The skill shared task should be identified in the documentation as 'delivered by skill share-trained (*insert profession*) implementing CTI S-AD04: Assess toileting and provide basic/bridging intervention" or similar wording.

# References and supporting documents


- Clark J, Rugg J (2005). The importance of independence in toileting: views of stroke survivors and their occupational therapists. British Journal of Occupational Therapy 68(4)
- National Ageing Research Institute (2005). Falls risk for older people – Community setting (FROP-Com): Guidelines. Available at: https://www.saskatoonhealthregion.ca/locations_services/Services/Falls-Prevention/providers/Documents/Community%20Tools/fp-FROP-Com-Questionnaire.pdf
- Thompson JA, O'Sullivan PB (2003). Levator plate movement during voluntary pelvic floor muscle contraction in subjects with incontinence and prolapse: a cross-sectional study and review. International Urogynecology Journal 14:84-88. DOI 10.1007/s00192-003-1036-5
- Queensland Health (2017). Guide to Informed Decision-making in Health Care (2nd edition). Available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0019/143074/ic-guide.pdf

# Assessment: performance criteria checklist

## S-AD04: Assess toileting and provide basic/bridging intervention

**Name:** **Position:** **Work Unit:**

| Performance criteria | Knowledge acquired | Supervised task practice | Competency assessment |
|---|---|---|---|
| | *Date and initials of supervising AHP* | *Date and initials of supervising AHP* | *Date and initials of supervising AHP* |
| Demonstrates knowledge of fundamental concepts required to undertake the task through observed performance and the clinical reasoning record. | | | |
| Identifies indications and safety considerations for the task and makes appropriate decisions to implement the task, including any risk mitigation strategies, in accordance with the clinical reasoning record. | | | |
| Completes preparation for the task including completing an equipment safety check, ensuring the environment is cleared and the client is wearing suitable footwear. | | | |
| Describes the task and seeks informed consent. | | | |
| Prepares the environment and positions self and client appropriately to ensure safety and effectiveness of the task, including reflecting on risks and improvements in the clinical reasoning record where relevant. | | | |
| Delivers the task effectively and safely as per the CTI procedure in accordance with the Learning Resource.<br>a) Clearly explains and demonstrates the task, checking the client's understanding.<br>b) Collects a toileting history from the medical record and subjectively from the client/carer.<br>c) Confirms the client's ability to participate in a toileting assessment including observation of sitting balance and standing transfer.<br>d) Observes the client walking to the toilet (with an aid if relevant) including locating the toilet, opening/closing the door and negotiating thresholds.<br>e) Observes the client's performance of toileting using Table 1 in the Learning resource.<br>f) Describes toileting performance including compensatory strategies and limitations.<br>g) Determines if the client would benefit from a basic/bridging intervention/s.<br>h) Selects appropriate intervention/s.<br>i) Develops a plan with the client for the planned intervention/s. | | | |

| | | | |
|---|---|---|---|
| j) Implements the agreed planned intervention/s, including observation of the client using the technique/equipment.<br>k) Makes any adjustments to the plan.<br>l) Determines if the client will require review and/or rehabilitation.<br>m) During the task, maintains a safe clinical environment and manages risks appropriately | | | |
| Monitors for performance errors and provides appropriate correction, feedback and/or adapts the task to improve effectiveness, in accordance with the clinical reasoning record. | | | |
| Documents in the clinical notes including a reference to the task being delivered by the skill share-trained health professional and the CTI used. | | | |
| If relevant, incorporates outcomes from the task into an intervention plan e.g. plan for task progression, interprets findings in relation to care planning, in accordance with the clinical reasoning record. | | | |
| Demonstrates appropriate clinical reasoning throughout the task, in accordance with the Learning Resource. | | | |

**Notes on the service model in which the health professional will be performing this task:**

*For example: the type of setting (community, medical assessment planning unit), additional client groups in scope e.g. weight bearing restrictions or types of walking aids.*

**Comments:**

**Record of assessment competence:**

| | | |
|---|---|---|
| Assessor name: | Assessor position: | Competence achieved: / / |

**Scheduled review:**

| | |
|---|---|
| Review date: / / | |

# S-AD04: Assess toileting and provide basic/bridging intervention

## Clinical reasoning record

- The clinical reasoning record can be used:
  - as a training resource, to be completed after each application of the skill shared task (or potential use of the task) in the training period and discussed in the supervision meeting.
  - after training is completed for the purposes of periodic audit of competence.
  - after training is completed in the event of an adverse or sub-optimal outcome from the delivery of the clinical task, to aid reflection and performance review by the lead practitioner.
- The clinical reasoning record should be retained with the clinician's records of training and not be included in the client's clinical documentation.

Date skill shared task delivered: _____

## 1. Setting and context

- insert concise point/s outlining the setting and situation in which the task was performed, and their impact on the task

## 2. Client

**Presenting condition and history relevant to task**

- insert concise point/s on the client's presentation in relation to the task e.g. presenting condition, relevant past history, relevant assessment findings

**General care plan**

- insert concise point/s on the client's general and profession-specific/allied health care plan e.g. acute inpatient, discharge planned in 2/7

**Functional considerations**

- insert concise point/s of relevance to the task e.g. current functional status, functional needs in home environment or functional goals. If not relevant to task - omit.

**Environmental considerations**

- insert concise point/s of relevance to the task e.g. environment set-up/preparation for task, equipment available at home and home environment. If not relevant to task - omit.

**Social considerations**

- insert concise point/s of relevance to the task e.g. carer considerations, other supports, client's role within family, transport or financial issues impacting care plan. If not relevant to task - omit.

**Other considerations**

- insert concise point/s of relevance to the task not previously covered. If none - omit.

## 3. Task indications and precautions considered

**Indications and precautions considered**

- insert concise point/s on the indications present for the task, and any risks or precautions, and the decision taken to implement/not implement the task including risk management strategies.

## 4. Outcomes of task

- insert concise point/s on the outcomes of the task including difficulties encountered, unanticipated responses

## 5. Plan

- insert concise point/s on the plan for further use of the task with this client including progression plan (if relevant)

## 6. Overall reflection

- insert concise point/s on learnings from the use of the task including indications for further learning or discussion with the lead practitioner

| **Skill share-trained health professional** | **Lead health professional (trainer)** |
|---|---|
| Name: | Name: |
| Position: | Position: |
| **Date this case was discussed in supervision:** | **/ /** |
| **Outcome of supervision discussion:** | e.g. further training, progress to final competency assessment |

# Assess toileting and provide basic/bridging intervention: Learning resource

Toileting is a fundamental daily activity. Independence in toileting is important to avoid the need for assistance and for maintaining self-esteem. A study of stroke survivors also rated the method of toileting as important, not merely that toileting is conducted independently (Clark and Rugg, 2005).

Problems with toileting can have health effects including recurrent urinary tract infections, fungal infections, risk of pressure injury and falls. A toileting assessment identifies problems and guides decision making including equipment needs, assistance requirements and rehabilitation goals.

The toileting process tends to be relatively similar between people i.e. the removal of clothing covering the perineum is required prior to voiding and the performance of perineal hygiene prior to clothing replacement. However, individual preferences for toileting may include leaving the door open, completing the adjustment of clothing prior to, or after disposing of waste or hand hygiene. History taking and observation of toileting should therefore be tailored to suit the client's preference, providing overall safety, hygiene and effectiveness are maintained.

## Required reading

### Toileting

- Bright B, Lewis C (2017). The importance of toileting evaluation in fall reduction of the older adult population fall risk and toileting in the older adult population. Open Access Journal of Gerontology and Geriatric Medicine. 2(2). Available at: https://juniperpublishers.com/oajggm/pdf/OAJGGM.MS.ID.555584.pdf
- Sato A, Okuda Y, Fujita T, Kimura N, Hoshina N, Kato S, Tanaka S (2016). Cognitive and physical functions related to the level of supervision and dependence in the toileting of stroke patients. Physical therapy research. 19. Available at: http://www.japanpt.or.jp/upload/jspt/obj/files/journal_e/PTR_19_E9904.pdf

### Continence

- Local processes/protocols/funding scheme requirements for continence products e.g. Department of Veteran Affairs, Medical Aids Subsidy Scheme, National Disability Insurance Scheme.
- Queensland Government Medical Aids Subsidy Scheme (MASS) (2010). First steps in the management of urinary incontinence in community-dwelling older people: A clinical practice guideline for primary clinicians (registered nurses and allied health professionals) Third edition. Available at: https://www.health.qld.gov.au/mass/prescribe/continence/resources
- Queensland Government. Home and Community Care (HACC)/Medical Aids Subside Scheme (MASS) Continence Project (2012). Did you know some medical conditions can cause bladder or bowel problems? Available at: https://www.health.qld.gov.au/__data/assets/pdf_file/0027/432864/consumer-guide-continence.pdf

### Toileting equipment

- Independent Living Centres Australia: Bathing equipment (2021). Available at: http://ilcaustralia.org.au/Using_Assistive_Technology/in_the_home/bathroom

- Manufacturer instructions for use should be reviewed for items e.g. long handled bottom wiper, urinal bottle, modified clothing.

# Guide to conducting a toileting history

## Environmental

- Identify the location of the toilet that the client regularly uses to undertake toileting e.g. commode beside the bed, in the garden, outside drop toilet or urinal bottle. Confirm if this is the same for both the bladder and bowel.
- Describe the toilet environment e.g. toilet in separate room, adjacent vanity, adjacent bath or shower, regular pan or disabled pan, side or rear sewerage outlet, position of the door in relation to the toilet, floor surface, stairs and the gradient change to access and general circulation space as it relates to the client, mobility aid and/or carer.
- Determine if the same toilet is used for both day and night-time toileting e.g. commode beside the bed or bottle at night and outside toilet during the day with stair access.
- Identify if the client currently uses/requires any equipment during the task e.g. grab rails, toilet seating equipment, bucket, milk bottle, continence products, long handled wiper, flushable wipes.

## Mobility

- Determine how the client mobilises to the toilet e.g. walks, walking aid, wheelchair, mobile commode. Check the Indication and limitations section of this CTI. Refer to mobility history from CTI S-MT01: Assess functional walking.
- What position does the client void in i.e. standing, sitting or squatting?
- Has the client had any falls in the past 12 months? If yes:
  - how many?
  - where e.g. in the bathroom, on the stairs?
  - were any injuries sustained e.g. bruising, fractures, lacerations, loss of consciousness?
  - what was the cause e.g. syncope, dizziness, wet floor?
  - which direction did the client fall i.e. forwards, backwards, to the side?

  Determine if the client meets local protocols for a falls assessment.
- When the client is moving in and around the toilet environment, does the client report or appear unsteady, or at risk of losing balance? e.g. standing up from sitting, during hygiene or whilst walking and turning.
- Has the client had any recent change to their medications? Some side effects for medications include symptoms such as dizziness or changes to blood pressure.

## Continence

- If the client has a supra-pubic catheter or colostomy, tailor questions to the bladder or bowel as relevant. Confirm how the emptying of devices occurs into the toilet e.g. standing independently, carer support.
- Determine how often the client needs to go to the toilet during the day and at night. Needing to go to the toilet three or more times per night on most nights is a risk factor for falls (National Ageing Research Institute, 2005).

- Is the client aware of the need to void? If no, does this occur during the day, the night or when having a nap? Refer to a health professional with expertise in the prescription of continence products. Continue with the assessment if the client has a goal for accessing the toilet e.g. bowels, daytime only or as part of a toileting regime.
- Does the client make it to the toilet on time? Does the client experience any urgency or leakage? This includes an inability to hold urine when coughing, laughing or waiting to go to the toilet. Experiencing urinary (urge or stress) or faecal incontinence or needing to rush to the toilet is a risk factor for falls. As part of the assessment consider timing and set-up requirements for the task. If the client has not previously seen anyone for, or has experienced an exacerbation in, incontinence consider referral to a health professional with expertise in continence for management options.
- Does the client currently use any continence products such as pull-ups, pads or panty liners? A client may use continence products as part of their continence management program e.g. liners for urinary leakage with toilet use for voiding/emptying bladder and bowel. Clients who are prescribed continence products may still require a toileting assessment. If the client requires continence products and does not access the toilet, determine the need for assessment e.g. change in mobility, change in cognition or change in communication ability.
- Does the client have any difficulty voiding or experience constipation? How does the client manage these symptoms e.g. timing, medication or positioning? If the client uses medication, confirm if these have been prescribed. If using suppositories, confirm how these are inserted e.g. self or with support. If the client reports difficulty with insertion, seek support from a health professional with expertise in suppository administration e.g. nurse.
- If the client has constipation or urinary frequency/urgency:
  - ensure that the assessment includes task timing that is reflective of their urgency and frequency requirements.
  - provide standard information to the client regarding management options including indications and options for accessing pelvic floor muscle re-training and incontinence products and referral processes to a continence nurse, women's health physiotherapist or medical practitioner.

  Note: contraction of the pelvic floor is not automatic on verbal instruction and if performed incorrectly may be detrimental (Thompson and O'Sullivan, 2003). Pelvic floor exercise prescription should therefore only be performed by suitably trained health professionals

## Clothing management

- Determine if the client has problems adjusting clothing when going to the toilet or when finished e.g. can't undo fasteners in time, prefers to wear loose dresses, unable to uncover the perineum without soiling clothing.

## Hygiene

- How does the client clean themselves after voiding e.g. shake, wipe or wash (bidet/shower)?
- If the client prefers showering, does this have an impact on their quality of life e.g. due to frequency or safety? If yes, liaise with a health professional with skills in shower assessment e.g. CTI S-AD06: Assess showering and provide basic/bridging intervention.
- If the client prefers to wipe, what does the client wipe themselves with and how e.g. paper, wipes, long handled wiper? Does the client report any difficulties e.g. incomplete wiping or urinary tract infections?

- What position is the client in when they are wiping e.g. standing, sitting, or leaning to one side? Does the client require or use any hand support e.g. rail, hand basin or wall? If yes, liaise with a health professional with skills in grab rails e.g. CTI S-AD01: Prescribe, train and review use of bathroom grab rails.
- How does the client wipe themselves i.e. front to back, back to front, reach between legs, reach behind? For women wiping back to front, there is an increased risk of urinary tract infections due to bacteria from faecal matter being transferred to the opening of the urethra. Provide education to the client to avoid wiping across the urethra to reduce the risk.
- How does the client manage the waste products after toileting e.g. flush or if relevant, dispose of continence products and/or commode bowl? For continence products, where is the bin and how is it emptied? For the commode bowl, how is it transported and cleaned? Determine if the management plan is safe, hygienic and effective.
- How does the client clean their hands after going to the toilet? If the client does not clean their hands, determine the reason e.g. tight tap handles, personal preference, standing balance at the sink or manoeuvrability of their mobility aid in front of the sink. Develop an appropriate management plan for hands including the use of hand wipes, gels and/or tap maintenance. If due to personal preference, provide education regarding the risk of harm to themselves and others due to transmission of disease and contamination.

### Client/carer goals

- Determine the client's goals and preferences for toileting.
- What does the client have to be able to do to toilet for their planned discharge destination, planned residence or to remain at home e.g. independent or assistance available?
- If the client has a carer:
  - what support are they able to and not able to provide e.g. with hygiene, clothing adjustment, transfers or waste disposal?
  - what is the expected duration for carer support during toileting e.g. short term during surgical restrictions, permanently?
  - consider the need for a carer strain assessment as part of the management plan e.g. CTI S-SP02: Assess carer strain using the Modified Caregiver Strain Index (MCSI) and provide basic/ bridging intervention.
- Does the client (or carer) have any concerns or preferences for supporting toileting e.g. does not want a commode beside the bed at night or the presence of equipment in a shared toilet?

## Selecting a basic/bridging intervention

A range of common problems may be observed during toileting. Table 1 below provides a clinical reasoning guide to common problems and list a range of potential basic/ bridging interventions.

When selecting a basic/bridging intervention, the following should be considered:

- the level of independence required for toileting (short term and long term)
- client/carer goals
- the impact of the activity on fatigue, pain or other symptoms in the context of other daily activities and demands on the client.

The general hierarchy of interventions for toileting is:

- altering the environmental set-up

- providing education on dressing techniques, including adapted clothing
- providing equipment
- providing assistance e.g. verbal cueing or manual guidance/physical assistance.

The first three interventions can promote or maintain a client's independent performance of the activity and should be trialled before assistance of a carer is recommended. This general concept should be balanced with the client's safety, goals and ability to perform the task in a timely manner.

Each intervention has some specific considerations:

- environmental set-up:  acceptability by other user or carers
- education on toileting techniques: the client/carer's ability to train in use of the technique
- equipment:  required skills, cost, ease of use
- assistance: carer availability, willingness and capacity to support the client.

## Outcomes of a toileting assessment

- At the completion of the toileting assessment, a recommendation should be made regarding the client's ability to toilet. The recommendation will be one of the following:
  - safe to toilet independently i.e. the task was completed successfully and there is no required intervention. A note can also be included that the client should be re-referred should issues/concerns arise.
  - client requires assistance to toilet. This may be due to incomplete, inefficient or unsafe performance during the assessment. Documentation will include a list of the problems observed and the recommended intervention/s.
- Intervention/s will be developed in consultation with the client and aim to improve task performance and maintain modesty and safety for toileting. This may include a brief/bridging intervention to improve toileting performance.
- If support is required, information will need to include the carer providing the support to ensure safety and understanding of the role.
- A rehabilitation plan may also be required if the basic/bridging intervention does not achieve client goals. This may require further assessment and/or intervention by a health professional with expertise in the task or implementation of other skill shared task.

  Note: a client may be safe in toileting in aspects of the task (daytime, at the toilet) but require support for parts of the task (night-time, walking). Where this occurs requirements should be listed separately.

# Observation of toileting

**Table 1: Clinical reasoning guide to observing toileting performance**

| Component | Observation | Common problems | Basic/bridging intervention |
|---|---|---|---|
| Mobilise to the toilet | • CTI S-MT01: Assess functional walking.<br>• If in scope for the local implementation CTI S-MT02: Prescribe, train and review of walking aids.<br>• The client is able to mobilise to and in the toilet, including locating the toilet, opening/closing the toilet door and negotiating the doorway threshold. | • Inadequate circulation space in the assessment environment i.e. bumping into walls/sink, unable to turn in the room, unable to open/close door.<br>• Distance required to mobilise causes breathlessness, urinary urgency/leakage. | • Remove clutter from walkways and circulation spaces.<br>• Provide a urinal or commode to reduce walk distance.<br>• Mobility retraining program, toilet schedule training program, pelvic floor retraining program. |
| Adjustment of clothing to facilitate toileting | • The client is able to manipulate clothing zippers, buttons, ties, belt.<br>• When positioning to sit on the toilet, the client is able to pull clothing down and up to allow the perineum to be exposed over the toilet.<br>• If squatting, the client is able to pull clothing down/up and place clothing behind the knees to expose the perineum. | • Difficulty manipulating zippers, buttons, ties, buckles and clothing in a timely manner to expose the perineum.<br>• Poor positioning/neglect of limb/s during clothing adjustment due to problems with proprioception, muscle control, neglect, etc. | • Education on alternative clothing, modified clothing, long handled reachers or one-handed aids. See required reading.<br>• Liaise with a health professional with expertise in dressing assessment e.g. CTI S-AD03: Assess dressing.<br>• Dressing retraining program. |
| Management of pads/liners/pull ups for incontinence. (if relevant) | • The client is able to unwrap/unfold required products. Place product according to manufacturer's guidelines e.g. place/adhere to underwear, don/doff pull up. | • Difficulty removing packaging, unfolding or positioning product for effective use.<br>• Product is overly soiled resulting in increased weight and leakage affecting health, mobility, manipulation of product or social interactions.<br>• Difficulty disposing of soiled continence products. | • Liaise with product prescriber for alternative products available and product changing schedule.<br>• Place a bin in a convenient, accessible location. Provide continence product disposal unit. Example available at: https://australianageingagenda.com.au/2013/09/04/recycling-absorbent-hygiene-products-one-step-closer/ |

| Component | Observation | Common problems | Basic/bridging intervention |
|---|---|---|---|
| Sit to stand | • CTI S-MT07: Assess standing transfer. If equipment is present, the client is able to appropriately use the grab rail/s and/or toilet seating equipment. | • Pulling on sink/towel rail/toilet roll holder during sit to stand.<br>• Pushing up on toileting seating arm rests unilaterally resulting in tipping of equipment.<br>• Pushing up from the front of the toilet seat resulting in excessive forward trunk flexion and risk of falling forward. | • CTI S-AD05: Prescribe, train and review - toilet seating equipment.<br>• CTI S-AD01: Prescribe, train and review use of bathroom grab rails. |
| Balance during voiding | • The client is able to reach required equipment without loss of balance including toilet paper.<br>• The client is able to perform perineal hygiene without loss of balance. | • Client reaches for hand support, demonstrates loss of balance and/or excessive postural sway during sitting. | • Change environmental set up to reduce reach for toilet paper/continence products/waste bin, etc.<br>• CTI S-AD05: Prescribe, train and review - toilet seating equipment.<br>• CTI S-AD01: Prescribe, train and review use of bathroom grab rails.<br>• Rehabilitation program for sitting balance. |
| Voiding | • The client demonstrates an awareness of incontinence including noting soiling on pants/pads/liner/ underpants and replaces if required. | • The client continues to wear soiled pants/ pads/liner/underpants. Determine the cause e.g. lack of products available, unaware.<br>• If the client requests to void during assessment and reports or observed difficulty/inability to void, strain and/or pain during task, determine the location of pain. Symptoms may indicate a urinary tract infection, constipation or poor positioning during toileting. | • Liaise with a health professional with expertise in continence including the prescription of a toilet schedule training program or pelvic floor retraining.<br>• Liaise with the medical/healthcare team regarding symptoms. |

| Component | Observation | Common problems | Basic/bridging intervention |
|---|---|---|---|
| Care of perineum | • The client attends to personal hygiene including cleaning of perineum i.e. shake, wipe or wash. | • Reduced range of motion of upper limb and/or trunk to access perineum effectively.<br>• Lacks adequate grip strength to manipulate and/or wipe effectively with toilet tissue.<br>• Soiling on underwear and/or continence products. | • Clients with restricted movement may be able to clean themselves independently using a long-handled wiper. Example available at: http://ilcaustralia.org.au/search_category_paths/809<br>• Use of moistened toilet wipes may improve effectiveness due to reduced friction/ease of hold. Check manufacturers recommendations for disposal i.e. bin or toilet.<br>• Develop a plan for hygiene including assistance and/or retraining. |
| Hand hygiene | • Client washes hands at the sink or has an alternative appropriate hand hygiene regime. | • Access to the sink is limited due to standing balance, manoeuvrability of mobility aid in front of sink.<br>• Tight tap handles or reduced grip strength. | • Education and removal of clutter.<br>• Review of walking aids e.g. CTI S-MT02: Prescribe, train and review of walking aids.<br>• Standing balance retraining program.<br>• Use of washer, hand wipes and/or anti-bacterial gel. Education available at: https://www.cdc.gov/handwashing/when-how-handwashing.html |
| Waste product management | • The client is able to dispose of toilet tissue and/or wipes including flushing of the toilet.<br>• Waste product disposal may also include placing continence products in bin/removal of commode pan or placing lid on bottle. | • Difficulty pushing button to flush toilet due to upper limb function or toilet flush stiffness.<br>• Unable to remove, carry and/or dispose of commode pan/urinal bottle/continence pad.<br>• Difficulty placing lid on bottle. | • Discuss waste disposal management plan with client and/or carer regarding acceptability methods e.g. carer flushes/family dispose of bin, flusher maintenance.<br>• Placement of bin in a convenient, accessible location for continence products.<br>• Trial a different pan/urinal bottle lid. |

| Component | Observation | Common problems | Basic/bridging intervention |
|---|---|---|---|
| | | | • Continence product disposal unit. Example available at: https://australianageingagenda.com.au/2013/09/04/recycling-absorbent-hygiene-products-one-step-closer/ |