Continence Policy

(Incontinence Management and Continence Promotion for Adults within Doncaster Care Groups Policy)

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1. **INTRODUCTION**

Incontinence is not a disease but a symptom of an underlying condition. Through informed assessment and investigation by a suitably trained professional, individuals suffering from bladder/bowel dysfunction may have symptoms resolved, improved or managed in the most appropriate way, without the primary focus placed on the supply of continence products. The importance of the assessment cannot be overestimated, as treatment for continence is dependent on the cause(s) (Button et al, 1999).

Following standards of best practice continence care will be delivered to all patients across all RDASH Doncaster Care Groups providing holistic assessment, advice and support and treatment plans.

2. **PURPOSE**

The purpose of this policy is to set out the criteria for provision of incontinence aids by Doncaster Specialist Continence Service (SCS). The aim is to provide a good quality integrated continence service as outlined in Good Practice in Continence Services (DH 2000), the National Service Framework (NSF) for Older People (2001). The needs of individuals with incontinence will be met, using research and education to promote continence and manage incontinence in an effective and comprehensive way. The philosophy of the SCS is to actively promote continence throughout all Doncaster Care Groups.

3. **SCOPE**

This policy applies to all clinical staff within all Doncaster Care Groups who deliver provide continence care to adult patients. It is recognised that primary care practitioners are also part of the organisation and as such this policy is offered for use by them to adapt to their own practices and organisations as appropriate. The author of the policy is available to offer help and support to primary care practitioners who wish to use and implement this policy. As part of good employment practice, agency workers are also required to abide by the RDaSH policies and procedures, as appropriate, to ensure their health, safety and welfare whilst undertaking work for RDaSH.

4. **RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES**

4.1 **Board of Directors**

It is the responsibility of the Board of Directors to have policies in place that meet any legislation, national and local requirements and promote best practice.

4.2 **Chief Executive**

The Board of Directors delegates to the Chief Executive the overall
responsibility for ensuring the Trust employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

4.3 Care Group Directors

Care Group Directors are responsible for the implementation of the policy within their specific areas.

4.4 Clinical Leads/ Matrons

It is the responsibility of Clinical Team Leaders/Matrons to ensure all staff adheres to the policy and the continence formulary. They must also ensure staff are given protected time to attend the continence awareness, continence care day and catheterisation study days.

4.5 Clinical staff

All staff must comply with this policy and related guidance.

5. PROCEDURE/IMPLEMENTATION

5.1 Referral pathway into the Specialist Continence Service (SCS)

The registered healthcare professional remains accountable for the initial assessment of continence and instigation of first line treatment, such as fluid and basic constipation advice, following guidance from the Trigger questions (See appendix 5). Referral to the SCS for a comprehensive bladder and bowel assessment should then be made if symptoms persist. Patients aged over 18, registered with a Doncaster GP may be referred by the following:

- Community Nursing Services
- Primary Care
- Secondary Care
- Social Care Providers
- Care Homes (with or without nursing)
- Other Healthcare providers

Referrals to the SCS should be triaged by an appropriate member of the SCS team following completion of a referral form (appendix 1). The patient will be assessed for eligibility and acuity based on the following tiered criteria:

- Urgent - assessments for patients not already on the SCS caseload, presenting with sudden incontinence
- Non-urgent - assessment/follow-up for patients on the SCS caseload with a recurring issue or mild exacerbation
- Planned – scheduling of planned activity, e.g. Trial without Catheter (TWOCs) to support patients discharged in to the community.
Patients, or their carer/advocate, should be asked to complete a symptom diary for the appropriate period of time, with an appointment being offered within a maximum of 15 working days from receipt of referral.

5.2 Exclusion Criteria

It is inappropriate to provide continence products where incontinence is secondary to underlying causes, such as:

- Patients requiring products for occasional use e.g., holidays, travel
- Urinary Tract Infection
- Inappropriate fluid intake
- Short term incontinence following surgical procedures such as back and hip operations, with the exception of prostatectomy patients
- Short term or one off tests e.g. sigmoidoscopy, barium enema
- Prolapses and vaginal/rectal bleeding

5.3 Assessment

Following receipt of referral and if applicable a holistic assessment will be undertaken.

For patients where it is known or anticipated there may be difficulties with maintaining bladder and/or bowel health e.g. learning disabilities, dementia or frailty, they should still have the opportunity for treatment before containment management options are implemented.

Referrals for “pad” assessments are not accepted. Pads should only be considered if all other strategies for promoting continence have failed

5.4 Exceptions to the 3 month trial of treatment are:

- Where the patient is terminally ill, or has become suddenly significantly incontinent due to illness e.g. severe Stroke
- Where the incontinence has occurred due to surgical interventions, drug therapy or radiotherapy
- Where the patient has cognitive understanding issues and treatment is not appropriate at this time
- Male patients who have undergone radical prostatectomy. These patients can have a one off 12 week delivery of containment products following a pad weigh. They will then be reassessed at 6 weeks in Specialist Continence clinic.

5.5 Initial Continence Assessment will include:

- History
- Patient goals and expectation of treatment
- Physical examination
- Symptom Diaries
• Stool Charts (See Appendix 2 for Bristol Stool Chart)
• Urinalysis
• Post-void urine measurement
• Medication Review (See Appendix 3)

5.6 **Conservative Treatment measures by the Specialist Continence Service will include:**

• Behavioural and lifestyle modifications
• Pelvic Floor exercises
• Bladder retraining
• Medication
• Devices/Products

A treatment/management plan should be agreed with the patient and a copy given to them (DOH 2000).

5.7 **Types of Incontinence**

*Please refer to the Urinary Incontinence in Adults Pathway (See Appendix 8)*

It is important to establish the type of urinary incontinence the patient is experiencing so that appropriate treatment can be advised. Treatment varies greatly from one patient to another, the underlying cause and its severity is largely individual. The embarrassing problem can be often treated with simple lifestyle changes but it may also need more invasive treatments including surgery.

For faecal incontinence, please refer to the Bowel Care Standard Operating Procedure, please refer to the clinical policies, RDaSH Intranet

5.8 **Aids and adaptations:**

There are many aids and appliances such as commodes and urinals available to help promote continence, many of which are available on the Continence Formulary

**Hand Held Urinals**

Hand held urinals are designed to be used by the patient or carer and are therefore smaller than traditional urinals or bed pans. They are invaluable for those who have impaired mobility and are unable to transfer or get to the toilet.

**Funnels and Directors**

Some men suffer from retraction of the penis into the body or a poor flow of urine and present with soiling of their clothes as the urine flows down the
front of the scrotum. If there is still some length of penis a urine director can be tried to direct the urine away from the body into the toilet bowl. A catheter night drainage bag may also be attached so that it can be used successfully overnight in bed.

A female funnel is also available for ladies who find that their stream of urine sprays outwards when sitting on the toilet. They may also find it useful to use a director into the toilet if they have difficulty with sitting down on the toilet.

**Male Sheaths**

Sheaths are a useful alternative method to manage urinary incontinence in men. Each patient should be assessed for:

- Correct length sheath-style
- Size
- Drainage system - adjustable tube leg bags must be used

Sheaths should be changed daily to aid pressure relief, personal hygiene and assessment of skin integrity. Soap and water is normally adequate for removal. In the event of a problem consider the use of an adhesive remover.

If a sheath is not successful, other alternative body worn appliances are available. Contact the SCS for details and assessment.

### 5.9 Lower Urinary Tract Symptoms in Males (LUTS)

Lower urinary tract symptoms (LUTS) comprise storage, voiding and post-micturition symptoms affecting the lower urinary tract. There are many possible causes of LUTS such as abnormalities or abnormal function of the prostate, urethra, bladder or sphincters. In men, the most common cause is benign prostate enlargement (BPE), which obstructs the bladder outlet.

The clinic offered by Specialist Continence Service is designed to optimise care for people suffering from LUTS without the requirement for accessing secondary care intervention in the first instance, and worsening symptoms in the second. The LUTS pathway is split into two pathways which a patient may fall into: LUTS with voiding symptoms and LUTS with storage symptoms. (Please see Appendix 7 for The Lower Urinary Tract Symptoms in Men Pathway.)

### 5.10 Home Delivery of Continence Products

Doncaster Specialist Continence Service offer a comprehensive service based on the principle of individual assessment. Following this assessment and conservative treatments have failed then an assessment of disposable and reusable continence products will be undertaken.
Eligibility to receive provision of body worn Incontinence Products

The Specialist Continence Service has overall responsibility for the provision and supply of continence products, following an assessment by health care professionals and an annual reassessment.

Provision Criteria

- Products are only provided after a comprehensive assessment and pad weighing. This will objectively assess the degree of incontinence and therefore enable the health care professional to prescribe products that will meet the client’s needs.
- Incontinence can be managed by a comprehensive range of products and pads should only be supplied in accordance with the continence provision guide.
- Annual reassessments of a patient’s symptoms

5.11 Continence Product Provision

- Patient’s that have a pad weight of less than 200mls will not be eligible for products.
- Maximum of 4 disposable pads in 24 hours will be prescribed. However if following a pad weigh individual results indicate a need for an increase in products this will be discussed with the Continence Senior Sister on an individual basis.
- Clients receiving the shaped range of products will be supplied with 5 pairs of fixation pants every 6 months.
- “All in one” products will only be provided to clients with a severe physical or mental impairment or for patients with profuse diarrhoea. Existing clients will continue to receive their current allocation of supplies.
- Tena pull up pants 2 pairs in 24hours. For patients who are toileting independently but struggle with the fixation pants and pad, i.e. patients suffering with dementia. Patient /carers and family members need to be informed that if more products are required they need to purchase these themselves. These are not to be prescribed for faecal incontinence. Patients who are on these products will be reassessed every 6 months to ensure that the products remain adequate for containment.
- Two washable absorbent bed sheets to be supplied every 12 months. For patients on an airwave mattress they can be prescribed kylie sheets or pad and pants not both. Following guidance from the Tissue Viability Specialist Nurse kylie sheets can be used on air wave mattresses as long as they are not tucked in.
- Where appropriate a combination of reusable and disposable products for day time and night time may be provided at the discretion of the Continence Senior Sister – SCS. Maximum of 3 disposable pads and 2 washable bed sheets. Again this is based on individual need.
• Advice should be given where appropriate about using other forms of continence management, e.g. sheath systems, intermittent catheters and urinals.

• Pad weigh has now become part of the continence assessment as incontinence is not easy to quantify. The Urodynamic Society (1997) have looked at recent research and evidence and now recommend the use of pad weighing as an objective assessment to record urine loss. Using this tool will clearly identify a patient's level of incontinence and will ensure the most suitable product to be prescribed. (See Appendix 4)

• Patients and their carers will be offered practical support, advice and a choice of appropriate products for coping with symptoms during the period of assessment and for as long as they experience episodes of faecal incontinence. Pads in quantities sufficient for the individual's continence needs will be prescribed (NICE 2007, 2014)

• Once assessed and products prescribed, non-housebound patients will be referred back to the Community Nursing Service for their annual continence reviews

5.12 Rapid Response

Community nursing staff attending End of Life (EOL) patients or patients in a crisis situation who require an emergency supply of continence products will have access to a supply of continence products to meet patient needs. The patient will be given 3 days' supply of products. The Community Nurse will complete the fast track prescription form, located on TPP under communications and letters, indicating that the patient is either EOL or in a crisis situation and that the patient has been given continence products (including the amount supplied from stock) to use prior to the 24 hour delivery.

Community nursing services must update the log sheet within the product store in order to evidence the management of stock levels and the appropriate use of products to meet the needs of EOL patients.

The ordering of all continence products will be carried out by SCS administration staff through the information provided on the fast track prescription form.

5.13 Annual Reassessments –

On an annual basis, all the house-bound patients will be reassessed by the Community Nursing Teams, while non-housebound patients will be continued to be reassessed by the SCS. Patients will be sent a reassessment letter advising them to contact the SCS within 14 days so that a review of their needs and associated products can be completed. Any patient that do not contact the SCS within 14 days of receipt of the letter, will be send another reminder informing them that if they fail to contact the service within the next 14 days then their products will be suspended until a reassessment is
performed. Once products have been suspended a re-referral to SCS will be required. Patients will be discussed at the initial assessments not sure what this sentence means

If a patient refuses to have a yearly reassessment then their products will be suspended until a reassessment is carried out.

Following reassessment patients who have been identified as having deterioration in symptoms must undergo a further pad weigh, to objectively assess the degree of incontinence so that the correct product can be prescribed to meet their clinical need. The pad weigh will be carried out at the patient’s home by a member of the SCS or Community Nursing Service.

5.14 Self-Care

A despatch note will be attached inside the delivery box. The despatch note contains the call back number and the date the next delivery will be available.

Self-Care is designed for re-activating deliveries only and cannot be used to bring a delivery forward or to change the type or number of products prescribed. If patients try to do this, housebound patients will be advised to contact the Specialist Continence Service as a reassessment may be needed. Patients that can attend a clinic will be sent an appointment to attend the reassessment clinic.

Continence products will be supplied every 12 weeks to community patients. All community patients have to call SCA to activate their next order.

5.15 Nursing, Residential and Learning Disabilities Care Homes

Care home deliveries are every 12 weeks. Care home deliveries are activated once the care home delivery order form has been sent to the SCS from the relevant home. This form includes a list of patient’s names that need their next delivery, any reasons for suspension i.e. Patient death, catheterised or improved needs to be documented. This form will only be accepted if the signature of the care home staff placing the order is eligible. It is the homes responsibility to ensure that all patients who are on the Home Delivery Service (HDS) have been added to the delivery form. Once the order has been activated and processed no changes can be made to the order. However if there has been a problem with the delivery they must contact SCS within 48 hours. After this time SCA will not be able to deal with any discrepancies.

Patients who take up temporary residency in another area within England/Scotland or another country should be placed on a temporary stop. If patients do not activate their order for a year then they will automatically be removed from the HDS. After this time the patient will need to be referred back into SCS to have a full continence assessment and pad weigh.
5.16 In-Patient Services

Pad use is based on individual holistic assessment and selection of the right product, if required. To maintain continuity of care, each ward will stock a core range.

Should continence symptoms become apparent during an inpatient stay, then a full continence assessment should be undertaken in order to ensure the most appropriate product is used.

On discharge, a referral should be made to the SCS for a Continence Assessment, if required a supply of 7 day supply of body worn products should also be provided.

6. TRAINING IMPLICATIONS

Staff will receive instruction and direction regarding the Promotion of Continence and information from a number of sources:

- RDaSH Policies/strategies and Procedures Manuals
- Clinical Line Manager
- Specialist Continence Service
- Guidelines for the Promotion of Continence and the management of Incontinence in Adults and Children
- Continence Awareness and Continence Care Training days
- Joint visits
- Bowel Care Study Day
- RDaSH Intranet

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<th>Staffing Groups Requiring Training</th>
<th>How often should this be undertaken</th>
<th>Length of training</th>
<th>Delivery method</th>
<th>Training delivered by whom</th>
<th>Where are the records of attendance held?</th>
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<td>9.30-4.30</td>
<td>Presentation</td>
<td>SCS team</td>
<td>Electronic Staff Record system (ESR)</td>
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<td>Qualified Staff TRH</td>
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Continence Awareness Day

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<th>Delivery method</th>
<th>Training delivered by whom</th>
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<td>SCS team</td>
<td>Electronic Staff Record system (ESR)</td>
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<td>Care Home Care Assistance</td>
<td>Every 3 years</td>
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<td>Home Carers (DMBC, Age Concern and other private agencies)</td>
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Bowel Care Day

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<th>Length of training</th>
<th>Delivery method</th>
<th>Training delivered by whom</th>
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<td>On employment</td>
<td>9.30-4.30</td>
<td>Presentation</td>
<td>SCS team</td>
<td>Electronic Staff Record system (ESR)</td>
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<tr>
<td>Qualified Care Home Staff</td>
<td>Every 3 years</td>
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<tr>
<td>Qualified Staff TRH</td>
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7. MONITORING ARRANGEMENTS

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<th>Area for Monitoring</th>
<th>How</th>
<th>Who by</th>
<th>Reported to</th>
<th>Frequency</th>
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<tr>
<td>Training compliance and following up on those who fail to attend</td>
<td>Follow up in writing with relevant trainers/managers</td>
<td>Continence Sister</td>
<td>Community Practice Educators and managers</td>
<td>Following every study day</td>
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<tr>
<td>Any patient feedback, complaints or Your Opinion Counts which relate to non-compliance with the standards in this policy</td>
<td>Investigation feedback and review</td>
<td>Matrons/Managers</td>
<td>Care Group Leadership and Quality groups</td>
<td>On-going or as the need arises</td>
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8. EQUALITY IMPACT ASSESSMENT SCREENING

The completed Equality Impact Assessment for this Policy has been published on this Policy’s web page on the RDaSH website.

8.1 Privacy, Dignity and Respect

The NHS Constitution states that all patients should feel that their privacy and dignity are respected while they are in hospital. High Quality Care for All (2008), Lord Darzi’s review of the NHS, identifies the need to organise care around the individual, ‘not just clinically but in terms of dignity and respect’.

As a consequence the Trust is required to articulate its intent to deliver care with privacy and dignity that treats all service users with respect. Therefore, all procedural documents will be considered, if relevant, to reflect the requirement to treat everyone with privacy, dignity and respect, (when appropriate this should also include how same sex accommodation is provided).

<table>
<thead>
<tr>
<th>Indicate how this will be met</th>
<th>Privacy, dignity and respect of the patient will be considered at all times. Sensitivity to the patient’s needs will also be addressed</th>
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8.2 Mental Capacity Act

Central to any aspect of care delivered to adults and young people aged 16 years or over will be the consideration of the individual’s capacity to participate in the decision making process. Consequently, no intervention should be carried out without either the individual’s informed consent, or the powers included in a legal framework, or by order of the Court.

Therefore, the Trust is required to make sure that all staff working with individuals who use our service are familiar with the provisions within the Mental Capacity Act. For this reason all procedural documents will be considered, if relevant to reflect the provisions of the Mental Capacity Act 2005 to ensure that the interests of an individual whose capacity is in question can continue to make as many decisions for themselves as possible.

<table>
<thead>
<tr>
<th>Indicate How This Will Be Achieved</th>
<th>All individuals involved in the implementation of this policy should do so in accordance with the Guiding Principles of the Mental Capacity Act 2005. (Section 1)</th>
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9. LINKS TO ANY ASSOCIATED DOCUMENTS

Standard Infection Prevention and Control Precautions Policy, Clinical Policies, Infection Control, RDaSH Intranet
Hand Hygiene Policy, Clinical Policies, Infection Control, RDaSH Intranet
Management of Blood and Body Fluids Spillages Policy, Clinical Policies, Infection Control, RDaSH Intranet
10. REFERENCES


11. APPENDICES
# Specialist Continence Service Referral Form

Email to doncaster.spa@nhs.net

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<td>Telephone:</td>
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<td>NHS Number:</td>
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### Reason for Referral:

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<tr>
<th>Bladder</th>
<th>Bowel</th>
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### High Risk:
- Bedbound
- Pressure Sores
- CVA within 12 Months
- CA Bladder
- CA Bowel
- Surgery within 6 Months
- Falls Risk

### Symptoms:

<table>
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<th>PSA Bloods taken?</th>
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<th>Prostate Assessment done?</th>
<th>Results:</th>
<th>DRE:</th>
<th>MSU taken?</th>
<th>Results:</th>
<th>Stool sample:</th>
</tr>
</thead>
</table>

PLEASE NOTE: IF PATIENTS PRESENT WITH ANY OF THE FOLLOWING, THEY MUST BE REFERRED TO SECONDARY CARE:

**Urgently refer:**
- Microscope haematuria if aged 50 years and older
- Visible haematuria
- Recurrent or persisting UTI
- Suspected pelvic mass arising from urinary tract
- Suspected CA prostate or CA bladder

**Refer with:**
- Symptomatic prolapse visible at or below the vaginal introitus

Consider referring with:
- Persisting bladder or urethral pain
- Clinically benign pelvic masses
- Associated faecal incontinence
- Suspected neurological disease
- Voiding difficulty, e.g. hesitancy, reduced flow rate, nocturia
- Suspected urogenital fistula
- Previous pelvic cancer surgery
- Previous pelvic radiation therapy

(NICE Guidelines Oct 2006)
- Residual urine > 200mls with deranged U+E’s

<table>
<thead>
<tr>
<th>IF PATIENTS PRESENT WITH POSSIBLE IRRITABLE BOWEL SYNDROME SYMPTOMS WITH ANY OF THE FOLLOWING, THEY MUST BE REFERRED TO SECONDARY CARE:</th>
<th>ASSESS AND CLINICALLY EXAMINE PATIENTS WITH POSSIBLE IRRITABLE BOWEL SYNDROME SYMPTOMS AND REFER TO SECONDARY CARE:</th>
</tr>
</thead>
</table>
| - Unintentional and unexplained weight loss  
- Rectal bleeding  
- A family history of bowel or ovarian cancer  
- People aged over 60, change in bowel habit lasting more than 6 weeks with looser and/or more frequent stools | - Anaemia  
- Abdominal masses  
- Rectal masses  
- Inflammatory markers for inflammatory bowel disease |

NICE has also produced a pathway on colorectal cancer

<table>
<thead>
<tr>
<th>Is there any blood in their urine/stools?</th>
<th>Do they have persistent pain in their bladder?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If yes to the above:

Have they seen their GP? If not, please refer to GP

<table>
<thead>
<tr>
<th>Is there any blood in their urine/stools?</th>
<th>Do they have persistent pain in their bladder?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If patient is being referred for constipation, what bowel care regime has been in place?

<table>
<thead>
<tr>
<th>Has advice been given on diet and fluid?</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

Past Medical History:

- □ Neurological Disorder  □ Dementia  □ COPD  □ Chronic Constipation
- □ Diabetic  □ Prostate Problems  □ IBS  □ Haemorrhoids

Other ………………………………………………………………………………………………………………………………………………………………………………………………

Have they ever had any surgery to their:

- □ Prostate  □ Bladder  □ Bowel  □ Gynae

If so, how long ago? ………………………………………………………………………………………………………………………………………………………………………………………………

Have they ever been seen by:

- □ Urology  □ Gynaecology  □ Physiotherapy  □ Continence  □ Gastroenterology
If so, how long ago? .............................................................................................................................

Medication:

How do they currently manage the problem?

Are they currently receiving products on the Home Delivery Service? ☐ Yes ☐ No

If so, what products are they receiving?
............................................................................................................................................................

Are they housebound? ☐ Yes ☐ No | Are they able to get to clinic? ☐ Yes ☐ No

Signature:
## The Bristol Stool Form Scale

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces ENTIRELY LIQUID</td>
</tr>
</tbody>
</table>
# Medication Likely To Effect Continence

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Use</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Social</td>
<td>Impairs mobility, reduces sensation, increases urinary frequency and urgency, induces diuresis</td>
</tr>
<tr>
<td>Anticholinesterase Neostigmine</td>
<td>Myasthenia gravis, Irritable bowel spasm</td>
<td>Bladder sphincter muscle relaxation causing involuntary micturition. Control of smooth muscle, increased peristalsis</td>
</tr>
</tbody>
</table>

## Antimuscarinic drugs also known as anticholinergics

| Benhexol, Procyclidine, Hyoscine, Propantheline | Parkinson's Disease, Drug induced Parkinsonism | Voiding difficulties |

## Drugs with antimuscarinic side effects

| Anti histamines, Pizotifen, Promethazine     | Allergies, Hay fever, Rashes, Migraine, Travel sickness | Voiding difficulties, Reduced awareness of desire to void |
| Anti depressants, Amitriptyline, Lofepramide | Depression                                               | Voiding difficulties |

## Calcium channel blockers

| Nifedipine | Angina, arrhythmia, hypertension | Nocturia, increased frequency |

## Cytotoxics

| Cyclophosphamide, Ifosfamide | Malignancies | Haemorrhagic cystitis |

## Diuretics

| Loop diuretics | Management of hypertension, Pulmonary oedema, Heart failure, oedema | Urinary urgency, Urge incontinence |
| Thiazides      | Diabetes insipidus, Oliguria due to renal failure, Ascites, Nephrotic syndrome | Urinary urgency, Frequency, Urge incontinence |

## Hypnotics/sedatives

<table>
<thead>
<tr>
<th>Antipsychotics, Chlorpromazine, Thioridazine, Droperidol, Haloperidol, Pimozide</th>
<th>Schizophrenia and related psychotic illness, Nausea, vomiting, agitation, Anxiety</th>
<th>Voiding difficulties, decreased awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benzodiazepines, Nitrazepam, Temazepam, Lorazepam</td>
<td>Sedation</td>
<td>Decreased awareness, impaired mobility</td>
</tr>
<tr>
<td>Barbiturates, Amylobarbitone, henobarbitone</td>
<td>Sedation</td>
<td>As above</td>
</tr>
<tr>
<td>Chlora derivatives</td>
<td>Sedation</td>
<td>As above</td>
</tr>
<tr>
<td>Drugs</td>
<td>Use</td>
<td>Effect</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>Sedation</td>
<td>Decreased awareness of desire to void</td>
</tr>
<tr>
<td>Chlorpromazine,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thioridazine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opiate analgesics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diamorphine, Morphine</td>
<td>Pain control, Drug</td>
<td>Bladder sphincter spasm causing difficulty in micturition and urge incontinence</td>
</tr>
<tr>
<td></td>
<td>abuse</td>
<td></td>
</tr>
<tr>
<td>Xanthines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theophylline,</td>
<td>Asthma</td>
<td>Increased diuresis, aggravates detrusor instability causing urge incontinence</td>
</tr>
<tr>
<td>Caffeine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4

Guidelines for the Prescribing of Continence Products in Patients Own Home

Following assessment and an appropriate management plan it may be necessary to prescribe products to contain the incontinence.

The products should be selected after considering the following:

- Amount of wetting
- Who is to change the pad
- Dexterity
- Whether the patient is mobile
- Urinary or faecal incontinence. If it’s faecal incontinence and the stools are solid absorbency is not an issue, rather containment of the stool
- Allergies
- Whether the patient is likely to tolerate the pad, e.g. patient’s with dementia may need an all in one to prevent “fiddling” or removal of the pad

Product assessment/Pad weighing

This will be done initially by the Continence Health Advisory Service

The decision on choice of pad will be influenced by the quantity of urine voided. This can be calculated by weighing pads.

- Pads should be collected for a period of 24 hours.
- Each pad should be put in an individual bag and tied.
- Attach a label to the individual bag, stating the type of pad, the time the pad was removed and if there has been any faecal soiling or leakage.
- Individual pad bags should then be stored in a larger bag,
- Faecally soiled pads should not be saved, however the Continence Health Advisory Service should be informed at the time of the pad weigh of any pads that have been discarded due to soiling
- The large bag containing the products should be stored away from any source of heat.
- Dry pads equivalent to those used will be weighed using a gram scale to establish a baseline.
- The wet pads will be weighed.
- The weight of a comparable number of the dry pads will be subtracted from the weight of the wet pads.
- 1 Gram = 1ml.
- This figure will give the amount of urine contained in the pads for the 24 hr period
- This information will be used to calculate the type, i.e. absorbency and number of pads required in a 24 hr period.
- The type of pad used may vary during the day depending on the pattern of incontinence. This can be identified using a baseline chart.
- Patient’s using diuretics may be very incontinent in the period following medication but may have decreased wetting for the rest of the day.
- The decision to prescribe all in one pads should be considered carefully. They are not necessarily more absorbent than a shaped pad.
- Pads will be ordered according to resident NEED.
- Patient’s will not be prescribed pads, “just in case” but if they require them should be given details of mail order services.
- Under no circumstances will incontinence pads be used solely as sanitary wear.
- The use of pads following “prescription” will be evaluated before finalising the order for Delivery Service.
# Appendix 5

### Trigger Questions around Bladder and Bowel Symptoms

| 1. | Is there any evidence that the patient may have a problem with their bladder or bowels?  
    - Is there an odour in the house?  
    - Are there any pads on show in the house? | If yes, ask the patient if they are having any problems with their “water works” or bowels. |
|---|---|---|
| 2. | Does it sting or burn when you pass water?  
    - Is there blood in your water? | INFECTION  
Urinalysis and/or MSU. Antibiotic treatment if advocated for clinic signs of infection. If repeated infection requires further investigation. |
| **Possible causes** | **Guidance** | **Possible causes** |
| INFECTION | Urinalysis and/or MSU. Antibiotic treatment if advocated for clinic signs of infection. If repeated infection requires further investigation. |
| **3.** | Do you leak when you cough/laugh/bend/lift a heavy object? | Stress incontinence due too poor pelvic floor tone  
Refer to the Continence Health Advisory Service |
| **Possible cause** | **Guidance** | **Possible causes** |
| Stress incontinence due too poor pelvic floor tone | Refer to the Continence Health Advisory Service |
| **4.** | Do you have an urgent need to use the toilet?  
Do you need to use the toilet frequently?  
Do you ever leak before you reach the toilet | Unstable bladder due to medical condition e.g. MS, CVA, Post Prostatectomy. Poor fluid intake/type of fluids, infection  
Bladder retraining. Advice on fluids. Refer to GP for Anticholinergic or Antibiotic Therapy. If no improvement in 3 months refer to Continence Health Advisory Service |
| **Possible causes** | **Guidance** | **Possible causes** |
| Unstable bladder due to medical condition e.g. MS, CVA, Post Prostatectomy. Poor fluid intake/type of fluids, infection | Bladder retraining. Advice on fluids. Refer to GP for Anticholinergic or Antibiotic Therapy. If no improvement in 3 months refer to Continence Health Advisory Service |
| **5.** | Do you only pass small amounts of water at a time?  
Does your bladder still feel full after passing water?  
Do you ever have to wait or strain to pass water?  
Is your flow weak?  
Do you have frequent water infections?  
Do you dribble continuously, or after passing water? | Incomplete emptying due to enlarge prostate, Stricture, faecal Impaction, neurogenic bladder or Bladder scan (Refer to Bladder Scan Flow Chart)  
Aids and appliances. Clear Impaction. Bladder stimulation, ISC, Refer to continence, Take U&E’s if |
| **Possible Causes** | **Guidance** | **Possible Causes** |
| Incomplete emptying due to enlarge prostate, Stricture, faecal Impaction, neurogenic bladder or Bladder scan (Refer to Bladder Scan Flow Chart)  
Aids and appliances. Clear Impaction. Bladder stimulation, ISC, Refer to continence, Take U&E’s if |
<table>
<thead>
<tr>
<th>Spinal Injuries</th>
<th>residual volume &gt;200mls.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>6.</strong></td>
<td></td>
</tr>
<tr>
<td>• Have sudden wetness without warning?</td>
<td></td>
</tr>
<tr>
<td>• Are you ever unaware that you have been incontinent?</td>
<td></td>
</tr>
<tr>
<td><strong>Possible causes</strong></td>
<td><strong>Guidance</strong></td>
</tr>
<tr>
<td>Passive incontinence due to mental impairment, dementia or confusion.</td>
<td>Habit retraining. Aids and appliances. Adapt the environment. Prompting, Toilet programme</td>
</tr>
<tr>
<td><strong>7.</strong></td>
<td></td>
</tr>
<tr>
<td>• Do you wet the bed?</td>
<td></td>
</tr>
<tr>
<td><strong>Possible Causes</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Community only</strong>-referral to Laundry Services</td>
<td></td>
</tr>
<tr>
<td><strong>8.</strong></td>
<td></td>
</tr>
<tr>
<td>• Do you have problems with mobility resulting in incontinence?</td>
<td></td>
</tr>
<tr>
<td>• Do you have problems with dexterity resulting in incontinence?</td>
<td></td>
</tr>
<tr>
<td>• Do Your present facilities cause/contribute to your incontinence?</td>
<td></td>
</tr>
<tr>
<td>• Do you need to be reminded to go to the toilet to prevent incontinence?</td>
<td></td>
</tr>
<tr>
<td><strong>Possible Causes</strong></td>
<td><strong>Guidance</strong></td>
</tr>
<tr>
<td>Functional incontinence due to underlying clinical or environmental problems</td>
<td>Adapt the environment/clothing. Prompting toileting. Refer to Occupational Therapist and Physiotherapist</td>
</tr>
<tr>
<td><strong>9.</strong></td>
<td></td>
</tr>
<tr>
<td>• Do you suffer constipation?</td>
<td></td>
</tr>
<tr>
<td><strong>Possible cause</strong></td>
<td><strong>Guidance</strong></td>
</tr>
<tr>
<td>High fibre intake, low fluid intake, medication</td>
<td>Check fluid intake, review fibre intake, review medication. Speak with GP regarding soft laxative. Complete stool chart. No Changes in 4 weeks refer to Continence Health Advisory Service</td>
</tr>
<tr>
<td><strong>10.</strong></td>
<td></td>
</tr>
<tr>
<td>• Do you suffer from loose stools?</td>
<td></td>
</tr>
<tr>
<td><strong>Possible Cause</strong></td>
<td><strong>Guidance</strong></td>
</tr>
<tr>
<td>Infection, Constipation, Over use of laxatives, Query Bowel Disorders e.g IBS, Diverticular disease etc</td>
<td>Send stool sample. Review medication, Query overflow. Fibre intake. Stool chart. Refer to Continence Health Advisory Service</td>
</tr>
</tbody>
</table>
Appendix 6

Uncomplicated LUTS Pathway

Referral into CHAS
GP / Healthcare Professional / other

LUTS with Voiding Symptoms

Initial Assessment
Full History and Assessment of Bladder and Bowel
- Fluids
- Mid-Stream urine Sample
- Pre and Post void Bladder Scans
- Flo Meter Readings
- Symptom Diaries
- IPSS Score
- Digital Rectal Examination of Prostate
- Bloods, Urea and Electrolytes, PSA
- Bowel Assessment
- Consider Alpha Blocker

Review in 4-6 weeks

Improvement

Yes
No

Discharge
Commence Alpha Blocker (See formulary)

Review in 4-6 weeks

Improved

Yes
No

LUTS with Storage Symptoms

Initial Assessment
Full History and Assessment of Bladder and Bowel
- Fluids
- Mid-stream Urine Sample
- Pre and Post Bladder Scan
- Symptom Diaries
- IPSS Score

Nocturnal Polyuria

Rule out Medical Condition
Consider offering Loop Diuretics
3pm 20mg Furosemide

Frequency Urgency Urge Incontinence

Supervised Bladder Retraining
Life style and Behave Advice
Consider Alpha Blockers
Antimuscarinic (PVR See *below)

Review in 4-6 weeks
Commence Antimuscarinic for Over Active Bladder

Symptoms Persist

Yes
No
Discharge

Symptoms persist

Consider alternative Alpha blocker / Antimuscarinic (See Formulary)

Review in 4-6 weeks

Symptoms Improved

Refer to Urology

No

Yes

Discharged

No

Yes

Discharged
Urinary Incontinence in Adults Pathway

**Stress**
- Leaking on coughing, sneezing jumping

**OBA**
- Symptoms in frequency (>7 in 24 hours), nocturia, urgency and/or incontinence

**Night Enuresis**
- Wet at Night / nocturia > 2/night

**Possible Causes**
- Medication, CCF, OBA, Fluid intake, Immobility

**Functional**
- Won’t / Can’t go to the toilet

**Possible Causes**
- Mobility Problems, Dementia, Environmental Psychiatric

**Reflex**
- Bladder Empties without

**Possible Causes**
- Neurological disease, Medication, Spinal injuries, Mental function, diabetes

**Chronic Retention (Overflow/Dribble)**
- Continual/ terminal dribble, weak flow, frequency, large PRV, Straining to void, Unable to void, Hesitancy, Poor flow, Night Enuresis

**Possible Causes**
- Detrusor Failure
  - Neurological, Medication, Spinal injuries, Secondary to Obstruction, Diabetes

- Obstruction
  - Enlarged Prostate Constipation
  - Bladder Stones
  - Urethral Stricture
  - Vaginal Prolapse
  - Post-surgery

**Refer to Consultant Urologist, Gynaecologist or Geriatrician**

**Key**
- PVR: Post void residual
- CCF: Congested Cardiac Failure
- OAB: Over Active Bladder

*All text in red to be referred directly to Consultant*

Reference: NICE CG 171, CG97

Appendix 7
**Minimum History**

- When symptoms started, frequency, amount
- Current management, faecal incontinence
- Fluid Intake / diet / caffeine
- Medication
- Medical, surgical and obstetric history
- Previous continence surgery, pelvic cancer surgery, Radiation Therapy

**Minimum Investigation**

- Bladder Chart/3 day Symptom Diary
- Stool Chart
- Dipstick MSU
- Urea and Electrolytes
- Post void residual urine
  - (if > 200mls, refer if deranged U&E’s)

**Minimum Examination**

- Abdomen clinically benign pelvic mass
- Digital Rectum Examination
- Vaginal Examination
- Cough Stress, Suspected urogenital Fistulae
- Signs of CCF
- Mobility, cognition, neurological screen

Sub-type to be identified
N.B May have multiple diagnosis