Continence Care Policy

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Approved by: Janine Dailey
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Brief Summary of Document:
All Wales Bladder and Bowel Care Pathway

To be read in conjunction with:

Classification: Clinical Category: Policy Freedom Of Information Status: Closed

Authorised by: Caroline Oakley Job Title: Dir Of Nursing & Midwifery Signature: [Signature]
**Continence Care Policy**

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**Scope**  
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DIRECTORATE  
DEPARTMENT ONLY  
COUNTY ONLY

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<th>Staff Group</th>
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**Please indicate the name of the individual(s)/group(s) or committee(s) involved in the consultation process and state date agreement obtained.**

**Individual(s):** NICE Pharmacists  
**Date(s):**

**Group(s):** General Managers  
**Date(s):**

**Committee(s):** Directorate Nurses for distribution to all appropriate staff for comment  
**Date(s):**

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**RATIFYING AUTHORITY**  
(in accordance with the Schedule of Delegation)

**NAME OF COMMITTEE**  
Clinical Policy Review Group  
**FR**  
**May 2011**  
**Date Approval Obtained:** Amendments needed as per minutes.

**Date Equality Impact Assessment Undertaken:** 06/07/11  
**Group completing Equality impact assessment:** Janine Dailey  
Llinos Walters  
Jackie Hooper

**Please enter any keywords to be used in the policy search system to enable staff to locate this policy:** Continence
<table>
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<th>Document Implementation Plan</th>
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<tr>
<td><strong>How Will This Policy Be Implemented?</strong></td>
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1. **INTRODUCTION**

The Continence Service for Hywel Dda Health Board aims to promote continence by encouraging the use of continence care pathways as the first line strategy and discourages the use of incontinence pads before assessment and treatment has been considered.

The National Service Framework for Older People in Wales (WAG, 2006) requires that each health and social care provider develops and implements a written policy for continence care. This policy identifies the requirements for an Integrated Continence Service as defined in Good Practice in Continence Services (DOH, 2000) for the assessment, diagnosis, treatment and management of bladder and bowel dysfunction. This also complies with the principles of The Fundamentals of Care (WAG, 2003).

Bladder and bowel dysfunction have many different causes of which incontinence may be a symptom (Norton, 1995). For full definitions of lower urinary tract signs and symptoms, refer to the standardisation documents at [www.icsoffice.org](http://www.icsoffice.org). Quick Reference Guide Appendix 1

The conditions can affect anyone at any age and often with devastating effect on the individual’s quality of life. Sufferers experience loss of dignity, embarrassment and distress which may lead to social isolation. Incontinence should not be accepted as inevitable; thorough assessment, diagnosis, investigation and treatment can result in cure or improvement.

The financial cost of not assessing and treating incontinence is significant. In 2002 the total incontinence-related expenditure for the UK was in excess of £420 million, with the NHS purchasing £80 million worth of absorbent products alone (Euromonitor, 1999).

Prevalence: At least 2.5-4 million people are affected with urinary incontinence and between 432,000- 617,000 are affected with faecal incontinence in the UK (Royal College of Physicians, 2005). It is estimated that around 150,000 people in Wales suffer from incontinence (All Wales Bladder and Bowel Care Pathway, 2006). It is difficult to give an accurate figure as it remains an under-reported and ‘hidden problem’.

2. **SCOPE**

The policy applies to all healthcare staff/professionals employed by the Hywel Dda Health Board who are responsible for the care of adults suffering from bladder/bowel dysfunction and/or incontinence.

3. **AIM**

This policy aims to meet the continence needs of all individuals respecting culture, diversity, and sexuality. All care should be patient-centred, planned in conjunction with the multi-disciplinary team, and when appropriate extended to the patient’s family and/or significant others. Professionals are accountable for the care provided and it is important that continence care is evidence based clinical practice (NMC, 2008) (HPC, 2008).

4. **OBJECTIVES**

To give guidance to healthcare staff regarding treatment and management of bladder and bowel dysfunction using the All Wales Bladder and Bowel Care Pathways.

To ensure high quality and timely bladder and bowel care is provided to every individual which complies with national policies (WAG, 2006), guidelines (NICE 2006, 2007) and guidance notes (DOH 2000, WAG 2003).
To inform healthcare professionals of their role and responsibilities in continence care.

To facilitate appropriate referral to other specialities.

5. ROLES AND RESPONSIBILITIES
The Chief Executive has accountability to ensure that there is a service to achieve these objectives.

The Director of Nursing & Quality has responsibility to ensure systems are in place for staff to achieve the objectives.

The Community Directorate Nurse has responsibility for professional leadership and strategic leadership of the service.

The Senior Nurse Manager of the Community Directorate has responsibility to ensure resources are available to adhere to the objectives.

The Senior Sister/Team Leader has responsibility to ensure that standards of care as recommended by this policy are met. They have responsibility to identify and address staff training needs in relation to this.

5.1. The Continence Care Team:
- is responsible for providing specialist advice and support, to enable health care staff to apply first level continence assessments to patients in all care locations
- is responsible for developing local policies which incorporate national evidence based clinical practice guidelines and pathways of care to support Health Board-wide implementation and evaluation
- is responsible for monitoring quality through clinical audit, taking into account comments and complaints
- is expected to work in partnership with other organisations (eg other health boards, trusts, and statutory and voluntary organisations)
- is responsible for providing competency based education and training programmes to all levels of staff and the multi-disciplinary team. The Team will ensure that systems are in place to identify training needs and that training is provided in a flexible and appropriate way to meet the learning needs of staff
- is responsible for delivering a high quality and cost-effective service within the resources available
- is responsible for ensuring access to current evidence regarding promotion of continence and management of bladder and bowel dysfunction.

5.2. All healthcare professionals:
- are responsible and accountable for their own practice (NMC, 2008), (HPC, 2008)
- should be aware of the National Occupational Standards relating to continence care and familiarise themselves with these competencies (www.skillsforhealth.org.uk)
- will initiate simple treatment and health promotion to maintain continence and treat incontinence.
Healthcare support workers will work under the supervision of a Registered Nurse in the application of this policy and are responsible for communicating actions and observations to the Registered Nurse.

6. **PATIENT AND CARER EDUCATION**

Information and education for patients and their carers should be given in clear and easy language without jargon, and in both visual and auditory format. Clear advice should be given about measures to improve bladder/bowel problems.

7. **ALL WALES BLADDER/BOWEL CARE PATHWAY (AWBBCP)**

The All Wales Bladder/Bowel Care Pathway was launched by WAG in 2006 and is recognised as the assessment documentation of choice for adults. This is underpinned by the NSF for Older People (WAG, 2006). These pathways provide guidance to ensure safe, fair and evidence based approach to continence care. This policy embraces their use and is committed to ensuring their implementation in both primary and secondary care. The pathways will be audited at local and national level to determine their effectiveness and relevance to current practice.

7.1. **Accessing the Pathways**

The AWBBCP can be accessed via the Hywel Dda website or via HOWIS. Advice on accessing can be given by the Continence Service team.

7.2. **Levels of bladder/bowel assessment:**

7.2.1. **Level 1. Initial contact.**

After identification of the problem, the assessment will be carried out using stage 1 of the pathway and results will determine which pathway the patients will follow or if referral is required. This may be undertaken by the Healthcare professional who is responsible for the care of the patient in the hospital or community setting.

7.2.2. **Level 2. Specialised Continence Service.**

Referral can be made to other members of the multi-disciplinary team, including Continence Specialist Nurses, Physiotherapists, Dietician, Occupational Therapist Social Services and others e.g. Mental Health, Learning Disability, Parkinson’s, Stroke, Neuro-inflammatory.

7.2.3. **Level 3. Referral to Medical Consultant hospital services.**

The Continence Service may need to refer patients to Specialist Consultant services e.g. Urology, Uro-Gynae, Colorectal, Care of the Elderly, Neurology, Mental Health.

7.3. **Points to note**

- The assessment, treatment and management of patients with complex needs will be adapted to meet the needs of the individual.
- All patients must be assessed and placed on the AWBBCP for a trial of continence promotion. Prescribing a pad must not be the first line of action and pads must only be issued as a last resort (see Appendix 2 - Criteria and eligibility for free incontinence pad provision in the community).
- Patients must not be catheterised because of incontinence (RCP, 2006). Urethral catheterisation must be avoided at all costs and only considered if the patient is in retention or for palliative measures at the end of life.
- Patients must be interviewed by the assessing nurse. During a level 1 assessment and pathway completion, information may be sought from other carers/advocates involved in the care of the patient (if applicable and subject to capacity and consent). Differential
HYWEL DDA LOCAL HEALTH BOARD

(nursing) or actual diagnosis along with a management plan should be documented whenever possible.

- The assessing nurse should:
  1) agree a pathway following discussion with the patient to promote continence and/or management
  2) provide verbal/written advice and support to the patient and carers as supplied in the pathway.
  3) Patients undergoing continence promotion strategies will be reviewed at least 3-6 monthly.
8. **APPENDIX 1 - QUICK REFERENCE GUIDE TO DIFFERENT TYPES OF INCONTINENCE**  
(Adaptation from the International Continence Society definitions of Incontinence & All Wales Bladder/Bowel Pathway)

- **Stress incontinence** is the most common type. It occurs when the pressure in the bladder becomes too great for the bladder outlet to withstand. It usually occurs because the pelvic floor muscles which support the bladder outlet are weakened. Urine tends to leak most when the person coughs, laughs, or undertakes exercise (such as jumping or running). In these situations there is a sudden extra pressure ('stress') inside the abdomen and on the bladder. Small amounts of urine may leak, but sometimes it may be quite a lot and cause embarrassment. The common reason for the pelvic floor muscles to become weakened is childbirth. Stress incontinence is common in women who have had several children. It is also more common with increasing age and with obesity. It can also occur in men.

- **Urge incontinence** (unstable or overactive bladder) is the second commonest cause. This may cause the person to feel an urgent desire to pass urine. Sometimes urine leaks before they get to the toilet. The bladder muscle contracts too early and the normal control is reduced. In most cases, the cause of urge incontinence is not known. This is called idiopathic urge incontinence. It would appear that the detrusor (bladder muscle) transmits an incorrect message to the brain, causing the bladder to feel fuller than it actually is. Sometimes urge incontinence can occur because of problems with the brain or nerve pathways. For example, it can occur after a stroke, in some people with Parkinson's disease, in some people with multiple sclerosis or in some people with spinal cord damage or other brain disorders.

- **Mixed incontinence.** Some people have a combination of stress and urge incontinence. Most cases of urinary incontinence are due to the above causes. Other causes are less common and they can include;
  - **Overflow incontinence.** Where there may be an obstruction to the outflow of urine. The obstruction prevents the normal emptying of the bladder. A pool of urine constantly remains in the bladder that cannot empty properly. However, pressure builds up behind the obstruction. The normal bladder emptying mechanism becomes faulty and urine may leak past the blockage from time to time. An enlarged prostate gland in men is the common cause of this. Treatment depends on the cause.
  - **Functional Incontinence :** Occurs in people who have normal bladder control but are unable to reach the toilet in time. Patients with functional incontinence may have mental or physical disabilities which make it difficult to get to the toilet or to communicate the need to go to the toilet.
  - **Nocturnal Enuresis (Bedwetting)** occurs in many children, but some adults are affected too.

8.1. **References**


All Wales Bladder/Bowel Care Pathway (2006) WAG


Royal College of Physicians (1995) Causes, management and provision of services.


8.2. Related Relevant National Documents


8.3. National charities
Bladder and Bowel Foundation, Northants
Nurse helpline for medical advice: 0845 345 0165
Counsellor helpline: 0870 770 3246
General enquiries: 01536 533255
mailto:info@bladderandbowelfoundation.org

PromoCon, Disabled Living, Manchester, Tel: 0161 8342001

8.4. Acknowledgements
In order to reduce unfair variation and standardise practice ensuring the Health Board policy falls in line with national best practice and that our local population are fairly catered for in relation to containment of incontinence, the following NHS organisations were involved in a benchmarking exercise. They are listed under the names that were current at the time of the exercise.

- Airedale Primary Care NHS Trust Continence Service
- Bassetlaw Primary Care NHS Trust Continence Service
- Cardiff and Vale NHS Trust Continence Service
- Cambridge City and South Cambridgeshire Primary Care NHS Trust Continence Service
- Cornwall and Isles of Scilly Continence Service
- Cwm Taf NHS Trust
- East Cambridgeshire and Fenland Primary Care NHS Trust Continence Service
- Gwent Healthcare NHS Trust
- Hywel Dda NHS Trust
- North Somerset Primary Care NHS Trust Continence Services
- North Wales NHS Trust
- North West Wales NHS Trust
- Powys LHB
- Royal College of Physicians RCP audit Policy section
- Telford and Wrekin Primary Care NHS Trust Continence Service
9. **APPENDIX 2 - CRITERIA AND ELIGIBILITY FOR FREE INCONTINENCE PAD PROVISION IN THE COMMUNITY.**

9.1. **Adults**

Products for the containment of incontinence are only supplied following a comprehensive assessment using the Wales Bladder/bowel Care Pathways and NICE guidelines. It is always the aim of the Continence Service to promote continence; advice and interventions should be tried and evaluated before supplies are issued. Evidence of the assessment will be required prior to pads being issued.

Responsibility for the provision of incontinence pads rests mainly with the Health Service. However NHS organisations do not have a duty to supply them but do so at their discretion and within the resources available to them. It maybe that clients have to ‘top up’ their supplies by self-purchasing at times or if they require products outside the normal range provided.

Incontinence pads will not be provided for light incontinence where one small incontinence pad is used per day or where people are using panty-liners or sanitary towels. Priority will always be given to clients with severe incontinence problems.

Provision of incontinence pads will not normally exceed 4 per 24 hours. This will take into account fluid intake, number of carer visits, whether there is faecal incontinence as well etc. It is realised that some clients will require more than the average number of pads because of the specific nature of their problems, and these can be discussed with the Continence Advisor.

Bedding protection is not provided by the Continence Service, but advice may be given as to where products can be purchased.

Disposable underpads are only provided if body worn pads cannot be used for some reason, and for terminal care if necessary. Washable underpads would be the first option; maximum of 3/year. Disposable underpads are not provided as well as body worn pads.

Procedure sheets can be issued 1/day for bowel care procedures only.

Shaped pads should always be a first choice rather than ‘all in one’ products which hinder toileting and are undignified to wear. Limited supplies of net fixation pants will be supplied. Clients can be advised of where these can be purchased from. Pads maybe of a mixture of absorbencies for efficient use.

Pull-on incontinence pads will be issued at the discretion of the Continence Advisor. These will generally be kept for people who are mobile, have confusion or learning problems where they are unable to cope with the usual range of pads. They are to promote continence rather than purely act as containment products. Amounts are limited to 3 per day.

All products will be delivered to client’s homes via the Home Delivery Service at 8 -16 week intervals. Excess products (complete packets only) should be returned to the service.

The Service will supply products to clients in Residential homes but not to Nursing Homes. however the Service may assess and give advice to clients in Nursing Homes.

People receiving incontinence products should have their needs reassessed as necessary but at least yearly.
9.2. **Children**

Products will only be issued after a comprehensive assessment by an appropriate Healthcare Professional/multidisciplinary team. It is the aim of the Continence Service that children identified as having ‘special needs’ are given the opportunity to achieve social continence.

No child under the age of 4 years will be eligible for supplies of incontinence pads.

In order to qualify for products a child must demonstrate urological or neurological symptoms. If the child has learning/developmental delay products will not necessarily be issued if it is felt that there is potential to develop continence soon and that products could delay this process.

Incontinence products will not be issued for children with only nocturnal enuresis (bed-wetting). Advice may be given and referral to an enuresis clinic.

Provision of pads/nappies will not normally exceed 4 per 24 hours. It is recognised that some children with specific needs may require more than this and should be negotiated with the Continence Advisor. These products may be a mixture of ‘pull ons’ and nappies depending on need. Nappies/shaped pads will be supplied for night-time. ‘Pull ons’ will be supplied if a child is mobile and they aid toileting and the likelihood of achieving continence.

Reassessment of a child’s needs should take place 6 monthly to see if continence can be achieved.

Hywel Dda Health Board Continence Service, March 2011