

CONTINENCE POLICY

Approved by: **Trust Executive Committee**

On: **February 2017**

Review Date: **February 2020**

Corporate / Directorate: **Corporate**

Clinical / Non Clinical: **Clinical**

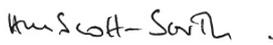
Department Responsible
for Review: **Corporate Nursing**

Distribution:

- Essential Reading for: **All Clinical Staff**
- Information for: **Managers**

Policy Number: **244**

Version Number: **2**

Signature: 
Chief Executive

Date: **18 April 2017**

Burton Hospitals NHS Foundation Trust

POLICY INDEX SHEET

Title:	Continence Policy
Original Issue Date:	December 2013
Date of Last Review:	
Responsibility:	Chief Nurse
Stored:	Intranet Site
Linked Trust Policies:	The Royal Marsden Hospital Manual of Clinical Nursing Procedures 8th edition Chapter 6
E & D Impact Assessed	EIA 324
Responsible Committee / Group	Professional Forum
Consulted	Urology Consultants, Colorectal Consultants, Members of the Professional Forum, Colorectal Nurse Specialist, Urology Nurse Specialists, Urogynae Nurse Specialist, Practice Development

REVIEW AND AMENDMENT LOG

Version	Type of change	Date	Description of Change
2	Update	27/03/2016	Whole policy reviewed and updated

CONTINENCE POLICY

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BURTON HOSPITALS NHS FOUNDATION TRUST

CONTINENCE POLICY

1. INTRODUCTION

1.1 Burton Hospitals recognises and provide a framework for Trust staff to facilitate appropriate information to patients who have a continence issue and give the appropriate details to achieve the following:-

- To ensure patients who may be able to gain/regain continence should have the right to access specialist NHS Continence Services in the community for full assessment and treatment.
- Service users who are unable to gain or maintain continence should be helped to ensure safe, comfortable and dignified ways of managing their incontinence.

2. THE SCOPE OF THE POLICY

This Policy aims to support healthcare professionals undertaking a continence assessment and supports the clinical decision making for adult patients

- 2.1 The policy aims to set a standard for the assessment of patients who have continence issues
- 2.2 This policy is applicable to all Health Care Professionals working in Burton Hospitals NHS Foundation Trust who assess patients for urinary and faecal Incontinence
- 2.3 Ensures patients are treated by an appropriately trained member of staff
- 2.4 This policy only relates to patients over the age of 18 years.

The “Good Practice Guidelines in Continence Care” (Department of Health, 2000) states all patients as part of their holistic assessment should be asked if they have a bladder or bowel problem, for some patients continence is not achievable and containment products will be required.

3. DEFINITIONS

Urinary incontinence is not a disease; it is a symptom of an underlying disorder affecting the bladder, urinary sphincter or pelvic floor. The primary aim of all health and social care professionals is to promote urinary continence wherever it is achievable.

3.1 Urinary Continence:

Continence is the ability to voluntarily control emptying the bladder and bowels effectively in a socially acceptable and hygienic way. NHS England 2015 .This is the ideal for everyone.

Urinary Incontinence:

This is defined by the British NICE Guideline (National Institute for Health and Clinical Excellence, October 2006) as 'the complaint of any involuntary leakage of urine'

Social Continence:

The patient is socially continent. This may involve the use of pads, appropriate appliances or internal devices (Dingwall 2008).

Dependent Continence:

This means the patient is dependent on others to take them, or remind them to go to the toilet (Abrams et al 2005).

Types of Incontinence

There are different types of incontinence:

Stress incontinence occurs when urine leaks as pressure is put on the bladder, for example, during exercise, coughing, sneezing, laughing, or lifting heavy objects. It's the most common type of bladder control problem in younger and middle-age women. It may begin around the time of [menopause](#).

Urge incontinence happens when people have a sudden need to urinate and aren't able to hold their urine long enough to get to the toilet. It may be a problem for people who have [diabetes](#), [Alzheimer's disease](#), Parkinson's disease, multiple sclerosis, or [stroke](#).

Overflow incontinence happens when small amounts of urine leak from a bladder that is always full. A man can have trouble emptying his bladder if an enlarged prostate is blocking the urethra. Diabetes and spinal cord injury can also cause this type of incontinence.

Functional incontinence occurs in many older people who have normal bladder control. They just have a problem getting to the toilet because of arthritis or other disorders that make it hard to move quickly.

3.2 Faecal Incontinence:

This is defined as the involuntary loss of faeces from the anus and is commonly classified according to:-

- symptoms
- character of leakage
- patient group
- primary underlying cause.

As such it is important to arrive at a diagnosis as to the cause/s for each individual.

Current epidemiological information shows that between 1-10% of adults are affected; depending upon the definition and frequency of faecal incontinence. It is likely that 0.5-1.0% of adults experience regular faecal incontinence which impacts on quality of life. For understandable reasons, it has remained a largely hidden problem, with many patients feeling too embarrassed or ashamed to admit to symptoms to healthcare professionals, or even to family and friends.

4. PATIENT ASSESSMENT

All adult patients will have a risk assessment completed on admission to hospital; part of this involves undertaking a continence assessment.

The following where possible should be adhered to:

- The assessment undertaken in private, where consultation cannot be overheard or the patient seen by members of the public or staff not involved with the assessment (Essence of Care 'Respect' Benchmark 2010).
- Confidential, only to be discussed with others with prior agreement by the patient.
- Adhere to infection control practices and procedures at all times.
- Clearly documented, in accordance with the Trust documentation standards, including all information and advice given.

4.1 Patients should always:

- Have the assessment discussed fully with them, and the registered nurse must always explain to the patient why the assessment is being performed, the course of treatment and the correct use of any aids or pads.
- Have their preferences and choices taken into consideration.
- Verbally agree to their course of treatment.
(A care/treatment plan to promote continence and/or manage incontinence must be verbally agreed, wherever possible, with the patient in line with the Mental Capacity Act (2005) and the Trust's Consent Policy. This must be documented in the patient's medical / nursing notes.)
- Be given a contact name and telephone number for follow up advice. See appendix 1
- Be offered translation/ interpretation facilities at the assessment if this is required.
It is best practice for any verbal advice to be supplemented with written information. (Essence of Care 'Respect' Benchmark 2010).

4.2 On identifying incontinence

The following should be undertaken for patients who are identified with incontinence issues:

- a urinalysis should be performed to exclude a urinary infection
- A MSU is sent if leucocytes, nitrates or blood are present and for all patients that are 65 or over irrespective.

- MSU should NOT be sent if only blood is present and the woman menstruating
- If persistent haematuria is present in the absence of a urinary tract infection, then a Urology referral should be made by the patient's consultant
- If urinalysis is negative or incontinence persists after treating with antibiotics, the patient can be advised to self refer to their local community continence team if their GP is based in Leicestershire (0300 300 1000) or Derbyshire 01773 546960. If their GP surgery is based in Staffordshire the patient should seek advice from their GP. For further information see appendix 1.

4.3 Faecal Incontinence Assessment

Healthcare professionals should carry out and record a focused baseline assessment for people with faecal incontinence to identify the contributory factors. This should comprise:

- Relevant medical history
- A general examination
- An anorectal examination
- A cognitive assessment, if appropriate.

Patients with the following conditions should have these addressed with condition-specific interventions before healthcare professionals' progress to initial management of faecal incontinence:

- Faecal loading
- Potentially treatable causes of diarrhoea (for example, infective, inflammatory bowel disease and irritable bowel syndrome)
- Warning signs for lower gastrointestinal cancer
- Rectal prolapse or third-degree haemorrhoids
- Acute anal sphincter injury including obstetric and other trauma
- Acute disc prolapse/cauda equina syndrome.

5. INITIAL MANAGEMENT

5.1 Roles and Responsibilities

- It is the responsibility of the staff following the initial assessment to ensure that pads are supplied to maintain patients dignity the pad should be the appropriate size for the degree of incontinence
- The ward nurse will ensure that the patient has the relevant information concerning who to contact regarding their incontinence issues
- It is the responsibility of the nurse to ensure that provision for continence care has been organised prior to discharge which includes a small supply of pads.

6. LONG TERM MANAGEMENT

Healthcare professionals should offer the following to symptomatic people who do not wish to continue with active treatment or who have intractable urinary and faecal incontinence:

- Advice relating to the preservation of dignity and where possible, independence psychological and emotional support
- Advice on continence products should be sort from the GP, district nurses and community continence team (depending on where their GP is based)
- Advice on skin care
- Advice on how to talk to friends and family
- You may be entitled to a radar key this can be obtained from either your local authority or by telephoning (see useful address or appendix 3).

Additional Faecal Incontinence Information:

- psychological and emotional support, possibly including referral to counsellors or therapists if it seems likely that person's attitude towards their condition and their ability to manage and cope with faecal incontinence could improve with professional assistance
- at least 6-monthly review of symptoms
- discussion of any other management options (including specialist referral)
- contact details for relevant support groups
- advice on continence products and information about product choice, availability and use

Inpatient Management:

- Incontinence pads should never be used for patients "just incase" pads should only be used after a full incontinence assessment has taken place. The appropriate pad size and absorbency should also be determined.
- All patients who identify that they have urgency to micturate during the continence assessment should have the following in place
 - Call bell or suitable alternative to summon help
 - Have a bed located as close to the bathroom as possible
 - Have all mobility aids at hand at all times
 - Have all sensory aids at hand at all times
- Patients who have incontinence should be supported to ensure that they remain clean and fresh at all times and any embarrassing smells are eliminated
- The patients privacy and dignity should be maintained at all times

Incontinence and Alzheimer's disease:

People in the later stages of Alzheimer's disease often have problems with urinary incontinence. This can be a result of not realizing they need to urinate, forgetting to go to the bathroom, or not being able to find the toilet. The care giver can:-

- Avoid giving drinks like caffeinated coffee, tea, and some sodas that increase urination. But [don't limit water](#).
- Keep the pathways clear and the bathroom clutter-free with a light on at all times.
- Make sure you provide regular bathroom breaks.
- Supply underwear that is easy to get on and off.

Older person:

Changes in elimination expected as the person ages:

- Bladder atrophy- inability to hold bladder for long periods.
- Constipation can become a concern because of slower metabolism.
- Men can develop prostate problems causing frequent need to urinate.
- Incontinence may occur because of lack of sphincter control. This can happen on standing even if the patient did not feel the need to go to the bathroom before they stood up.

Strategies for supporting people with changes in elimination:

- Maintain bathroom routines and ensure that all staff know what this routine is
- Decrease caffeine intake.
- Increase fiber and fluid intake.
- Exercise.
- Provide appropriate supplies and emotional support.
- Consider implementing sleep hygiene

7. FURTHER READING

For further information on urinary and faecal continence please refer to appendix 3 and 4.

8. MONITORING OF POLICY

It is essential that this Policy is monitored and accurately evaluated in order to ensure its continual effectiveness. The guidelines will be monitored on an on-going basis through data collected via the Trust's Clinical Incident reporting policy, through complaints and PALS concerns. Monthly audit will occur via the Quality Metrics.- I am not aware that we do monthly audits? Is there a proforma audit or is it through observation of privacy and dignity in relation to personal care? Any issues will be reported to the Matrons and Head Nurses and reported to the Quality & Safety Group.

9. PATIENT INFORMATION LEAFLETS

For urinary incontinence copies may be obtained via the Intranet found .via the intranet

For faecal incontinence copies may be obtained via the Internet.

10. USEFUL ADDRESSES

Bladder & Bowel Foundation

7 The Court,
Holywell Business Park
Northfield Road
Southam
CV47 0FS
www.bladder and bowel foundation.org
(no fax number no

PromoCon offers advice and information on products that can help manage bladder and bowel problems.

Tel. No. 0161 607 8219

Fax: 01616 078201 (new)

www.disabledliving.co.uk/Promocon/Helpline

Radar Key

Royal Association for the Disabled and Rehabilitation (Radar) Keys are available for anyone with continence problems. Keys are free. Most major towns have lists of local facilities.

Telephone : 02072 508181

<http://www.disabilityrightsuk.org>

Spinal Injuries Association

Free phone Advice Line

0800 980 0501

www.spinal.co.uk

The Cystitis and Overactive Bladder Foundation

Tel. No. 0121 702 0820

www.interstitialcystitis.co.uk

The Disabled Living Foundation

Helpline 0300 999 0004(10am-4pm Monday to Friday)

www.dlf.org.uk

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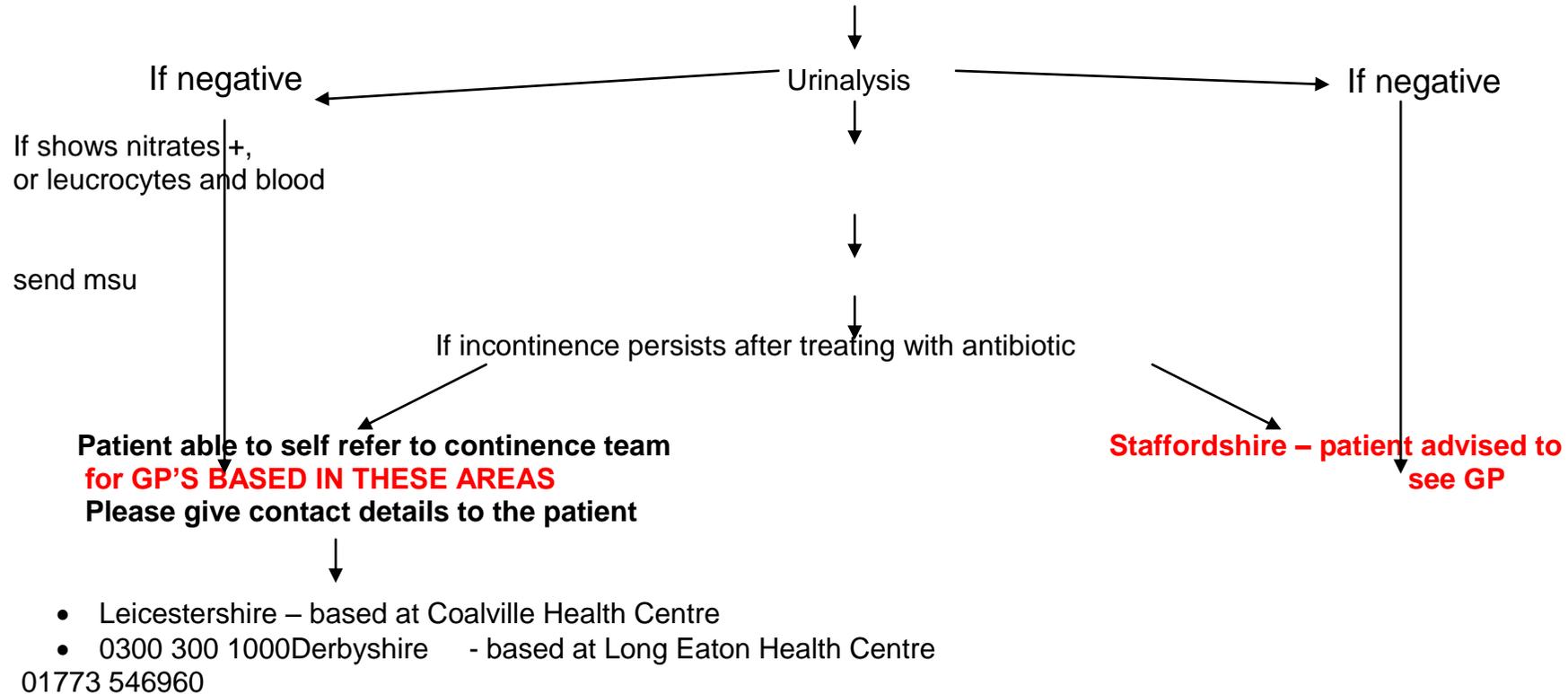
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APPENDIX 1

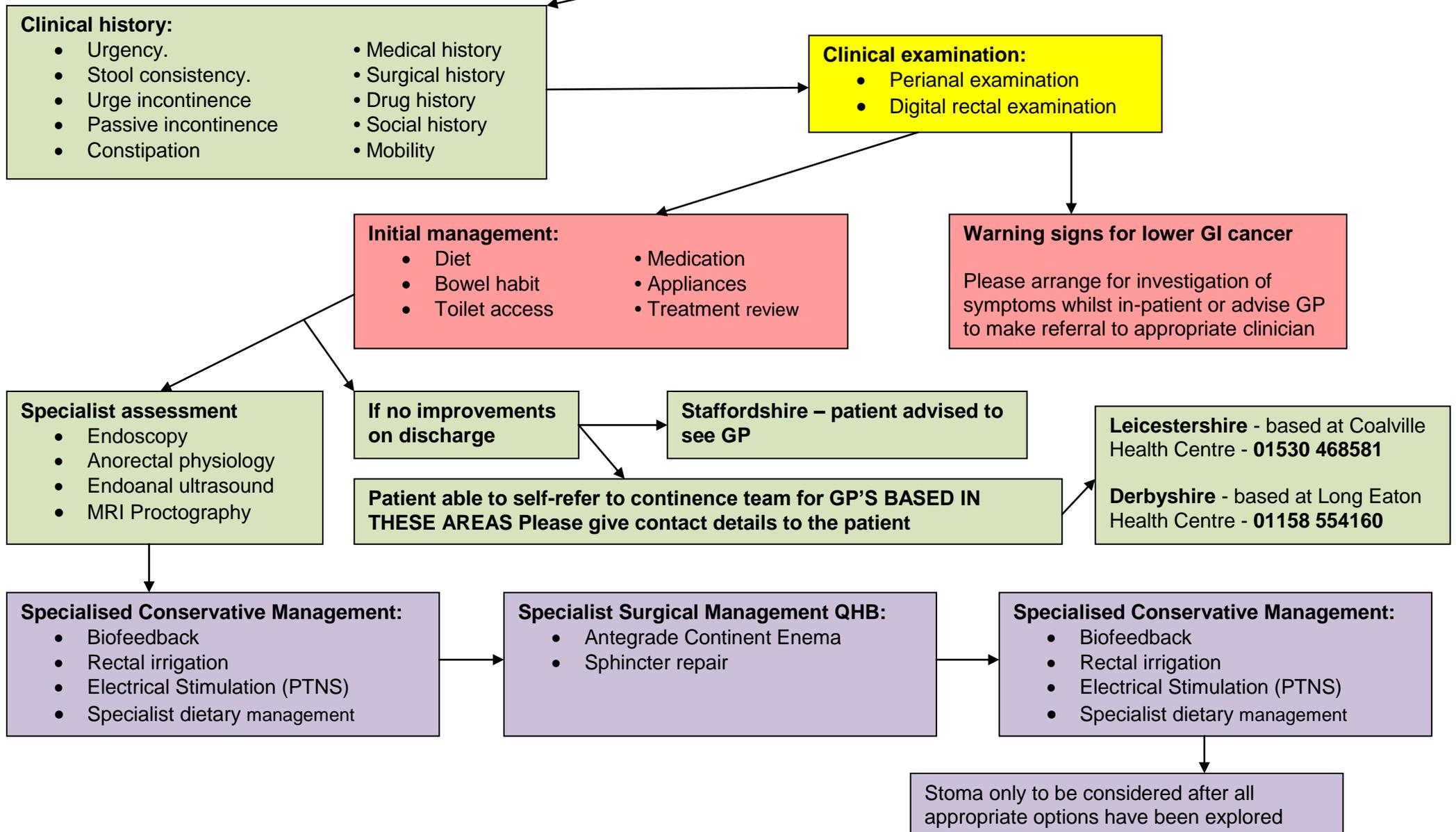
DISCHARGE GUIDELINES FOR MANAGEMENT OF URINARY CONTINENCE

Patient suffers with incontinence



APPENDIX 2

FLOW CHART FOR THE ASSESSMENT AND MANAGEMENT OF FAECAL INCONTINENCE



APPENDIX 3

Relevant Information (Urinary incontinence)

People who report or are reported to have urinary incontinence should be offered care to be managed by healthcare professionals who have the relevant skills, training and experience and who work within an integrated continence service (Good practice in continence services, 2000).

Causes of Incontinence

Pelvic Floor Weakness (Stress Incontinence)

This is demonstrated by the leakage of urine on coughing, sneezing, exercise or any activity, which raises the abdominal pressure. It is often due to urethral sphincter incompetence due to weak pelvic floor muscles, intrinsic sphincter weakness or surgery.

Common Causes:	Female	Childbirth, constipation, obesity
	Male	Radical prostatectomy

The Overactive Bladder (Urgency/Urge Incontinence)

This happens when the bladder muscle (detrusor) begins to contract before reaching the toilet and frequently leads to urge urinary leakage. A frequency of over 8 times a day may indicate bladder over activity

Many older women will present with mixed symptoms of urge and stress leakage and will need advice for both.

Common Causes: Bladder irritating drinks e.g. caffeinated tea, coffee, cocoa, fizzy drinks, orange and lemon drinks. Low fluid intake, urinary tract infection, constipation, pregnancy, diabetes and neurological conditions e.g. MS

Voiding Difficulty

This happens when there is an outflow obstruction. Poorly contractile detrusor or poor co-ordination of bladder contraction and sphincter relaxation or anything which will prevent the bladder emptying completely.

Common Causes: enlarged prostate in men, stricture, vaginal or uterine prolapse, Acute or chronic constipation, prolonged over distension of the bladder, diabetes and other neurological conditions e.g. strokes, spinal injuries or Multiple Sclerosis.

Reflex Incontinence

Reflex incontinence is indicated by involuntary loss of urine, leakage occurs in the absence of any desire to void and as a result of a neurological problem.

Common Causes: spinal injury, congenital abnormality, neurological conditions

Functional Incontinence

Occurs as a result of a medical condition outside the urinary tract, typically cognitive or physical impairment.

Immobility or lack of dexterity may restrict the client's ability to reach the toilet

Common Causes: Dementia, Parkinson's, CVA immobility, learning difficulties.

Nocturia

It is important to distinguish whether the desire to void is the reason for waking or whether the patient is awake anyway

Getting up once or twice to void is common over the age of 50.

Nocturnal polyuria is defined as passing more than one third of the daily output overnight.

Common Causes:

Nocturia; residual urine, urinary tract infection, diurnal disturbance, prostatic enlargement or detrusor instability.

Nocturnal Polyuria; heart failure, diabetes, pituitary tumour, postural oedema
(If taking diuretics take this either in the morning or 5 hours prior to going to bed)

Nocturnal Enuresis: Night time bed wetting is associated with either high pressure chronic retention with the risk of renal impairment.

High Risk Groups

People who report or are reported to have incontinence should be offered care by healthcare professionals who have the relevant skills, training and experience and who work within an integrated continence service (Good practice in continence services, 2000).

- post menopausal women
- People with pelvic organ prolapse
- Women following childbirth
- People with neurological disease/injury (for example, spina bifida, stroke, multiple sclerosis, spinal cord injury)
- People with severe cognitive impairment
- Older people
- Patients with Mobility or disability problems
- People who have learning difficulties
- People who have undergone pelvic radiotherapy
- Men with prostate problems
- Patients on medication i.e. diuretics, alpha blockers

Relevant Health History

The following aspects of the patient's health history must be taken into consideration:

- **Weight:** Increased body mass index is positively associated with loss of urine. Excess weight can increase abdominal pressure during physical activity, which may increase bladder pressure and urethral mobility (Dallosso et al 2002).
- **Obstetric History:** Risk factors for stress incontinence include weight of baby (over 8lb/4kg), trauma (episiotomy, tear), assisted delivery (forceps, suction), length of labour (long or short), epidural, number of babies, gaps between them (less than 2 years).
- **Surgery:** Previous surgery must be documented.
- **Gynaecological Surgery:** e.g. colposuspension, pelvic floor repair, hysterectomy, sling procedure, injectable urethral bulking agents.
- **Urological Surgery:** e.g. prostate surgery, bladder neck surgery, sling procedure, colposuspension, injectable bulking agents, cystoscopy, botox injection, urethral dilatation and stricture therapy.
- **Medical Conditions:** Many medical conditions can affect the function of the bladder. For example: neurological conditions: multiple sclerosis, diabetes, spinal injuries, stroke, dementia, back pain, chronic cough, depression, sexually transmitted diseases, (Chlamydia infections cause urgency) physical and learning disabilities. Also note any history of sexual abuse, age of menopause and Hormone Replacement Therapy (HRT) usage. Allergies must be documented.
- **Constipation:** Links have been found between chronic constipation and/or faecal impaction and nocturia, frequency, urgency and stress incontinence (NICE Guideline CG40 2006). Severe constipation and straining over a long period may cause changes in pelvic neurological function. Straining at stool has also been shown to be significantly more common in women with stress incontinence (NICE Guideline CG40 2006). Aim to treat the chronic constipation and review the patient following resolution of the constipation. (For further information regarding constipation, refer to the Trust Bowel Care Guidelines).

Smoking: There is some evidence cigarette smoking may be associated with increased risk of urinary incontinence as a consequence of frequent or violent coughing (Dallosso et al 2002). Smoking also carries an increased risk of bladder cancer.

Fluid intake: An accurate record of fluid intake, including type and amount is a vital part of the assessment. Caffeine is a diuretic and bladder stimulant, which can exacerbate urgency. Alcohol and caffeine containing fizzy drinks will have a similar effect. Many incontinent people use fluid restriction to manage their incontinence however; concentrated urine can irritate the bladder and cause urothelial irritation. See appendix 3

Toilet access

- Locations of toilets should be made clear to the individual where appropriate
- Equipment to help people to gain access to a toilet should be provided
- Advice should be given to people with incontinence on easily removable clothing to reduce time needed to access
- If a person with incontinence is dependent on others for access to the toilet, help should be readily available
- If appropriate, people with incontinence should be referred to the relevant professionals for assessment

You may be entitled to a radar key this can be obtained from either your local authority (some costs may be incurred for obtaining this key) carrying a toilet access card or RADAR key to allow access to disabled toilets in the National Key Scheme.

Medications

Many drugs have the potential to disturb lower urinary tract function (see Table 1). A regular review of medication (including over the counter remedies) is necessary to see whether doses may be reduced, stopped or taken at different times of the day. Polypharmacy (prescription of more drugs than is clinically justified (Reid 2005)) often occurs in older adults when medications are not reviewed in this way.

Table 1: Examples of drugs, which may affect lower urinary tract function.

Drug Group	Mechanism	Examples
Diuretics	Increase rate of bladder filling: exacerbate frequency and urgency	Thiazides Frusemide
Beta Blockers	Reduce sympathetic supply to the detrusor muscle: may enhance contractility	Atenolol Propranolol
Alpha Blockers	Reduce sympathetic supply to urethra: decreases urethral resistance	Prazosin
Major Tranquilisers	Anticholinergic effect: inhibit bladder	Chlorpromazine
Anxiolytics	Impair urethral function	Benzodiazepines
Anticholinergics	Increase urethral sphincter tone and decrease bladder contractility: urinary retention	Benzhexol Propantheline
Calcium channel blockers	Nocturia, increased frequency	Nifedipine
Anticholinesterases	Urethral sphincter muscle relaxation: involuntary micturition	Neostigmine
Opiate Analgesics	Urethral sphincter spasm: difficulties in micturition; urge incontinence	Diamorphine Morphine
Alcohol	Increased urinary frequency and urgency	
Caffeine	Diuretic activity plus detrusor overactivity	
Drugs with antimuscarinic side effects e.g. anti histamines, drugs to relieve migraine/travel sickness	Voiding difficulties Reduced awareness of desire to void	Pizotifen Promethazine

Other Factors to Consider

Mobility

Mobility should be observed. It may be impaired directly due to pain or indirectly due to fear of falling. The speed of mobility may be an issue when the patient has urinary urgency. For patients in whom the urinary incontinence has been exacerbated/ caused by inability to reach the toilet 'in time', ensure that they are positioned near to the toilet, have access to the call bell and receive assistance promptly

Dexterity

Manual dexterity is linked closely to mobility as it may hinder removing clothes to use the toilet or in the fitting of aids or appliances. Advice should be given to people with urinary incontinence on easily removable clothing to reduce time needed for access.

Mental and Cognitive Function

Confusion and dementia will affect awareness of bladder and bowels and needs careful assessment and often constant monitoring. The person may simply forget to go to the lavatory, either not noticing that the bladder is full, or not realising that something needs to be done about it. Some people need frequent reminders to visit the lavatory. Others benefit from a regular habit, such as always going before or after meals. Some confused people will become restless as their bladder nears its emptying capacity; they know that something has to be done but are not sure how or where to do it. Observe for these signs and use them in arranging the time of toileting. Someone who starts off to go to the lavatory may forget where they were going on the way.

Skin Condition

Assess for soreness, excoriation, broken areas, skin texture and colour using the Midland and East Pressure Ulcer Grading score should be used when making an assessment along with referring patient on to the Tissue Viability Team for guidance. Senset Cleansing Foam is to be used on all moisture lesions (One canister per patient to stop cross infection occurring).

Atrophic vaginitis may be present following the menopause or hysterectomy; the vagina and surrounding tissue is pale, dry and the patient may report feeling sore and itchy. This can lead to symptoms of frequency, urgency and urge incontinence, consider requesting a prescription of oestrogen cream.

Post Void Residual Urine

This is ideally measured by bladder scan. An increased residual volume predisposes the patient to infection or incontinence. Any post-void urinary residual urine may be due to obstruction or poor bladder contractility. Less than 100mls is considered normal and over 250mls abnormal (Gehrich A, et al 2007).

In routine clinical practice a raised residual volume is normally considered to be >250mls. If found, further investigation may be necessary. Knowledge of the residual volume may have an impact upon management, e.g. anticholinergic therapy can reduce bladder contractility therefore may be contraindicated if the residual volume is high.

In women if the bladder scan is high but the residual on catheterisation is minimal an urgent ultrasound of the pelvis should be considered to rule out an ovarian cyst.

Five Key Messages for Good Continence Care

- 1. Think Wet Skin** – It is the *responsibility* of every nurse to make every effort to ensure the integrity of incontinent patients' skin remains intact.
- 2. Promote good toileting** – We should aim to respond reliably and timely to the toileting needs of patients particularly in respect of Care Rounds. Does the patient really need to wear a pad? Promote an *honest* & open discussion with the patient & family if appropriate, to ensure the patient feels secure with their care plan.
- 3. Dignity & Respect** – All patients should be afforded the *respect & dignity* they require to enable them to discuss their continence issues in order for them to be addressed effectively.
- 4. Contain** – We must be responsive & *innovative* to the need of incontinent patients, in managing their urinary or faecal leakage reliably, by maintaining a good up to date knowledge of the best products available to meet their needs.
- 5. Deliver the Best Care** – We must ensure all incontinent patients requiring containment pads are assessed for the most appropriate absorbency according to the level of leakage; i.e. start with the minimum absorbency suitable.

TOP TIPS FOR PROMOTING CONTINENCE - Lifestyle Advice

- Avoid Infection
- Avoid Constipation
- Be aware of medication side effects
- Drink sufficient fluid i.e. 1.5 - 2 litres per 24 hours
- Limit caffeine
- Limit alcohol
- Eat a healthy balanced diet
- Regular exercise
- Exercise Pelvic Floor Muscle regularly see appendix –for Pelvic Floor Exercises leaflet (taught by the Continence Team)
- Avoid being overweight
- Stop Smoking
- Use Laxatives cautiously
- Maintain good toileting habits i.e. good routine/listen to body's signals/avoid bladder overfilling/don't go to the toilet unless you have to
Bladder Retraining Leaflet (taught by the Continence Team)

Continence team in the community

People can self refer in Leicestershire and Derbyshire or be referred by their GP's in Staffordshire for management of their urinary incontinence.

Facilities available include:

- Pelvic floor muscle training
- Bladder retraining
- Fluid and dietary assessment and management
- Containment management

Specialist treatment for incontinence

All patients who have failed conservative management should be considered for specialists' treatment. All people with incontinence considering or being considered for surgery should be referred to a specialist surgeon to discuss:

- The surgical and non-surgical options appropriate for their individual circumstances
- The potential benefits and limitations of each option, with particular attention to long term results
- Realistic expectations of the effectiveness of any surgical procedures under consideration

People with predominate symptoms of an overactive bladder will require lifestyle advice, supervised bladder training, advice on fluid intake and if required containment products. If this is unsuccessful anticholinergic medication can be prescribed by the General Practitioner and a trial of 2 different anticholinergics tablets. A referral to a urogynaecologist/urologist is made if the urinary problems continue.

Urodynamics may then be considered to obtain a diagnosis prior to considering surgery. Urodynamics is a study of how the bladder functions, by observing bladder pressures with the aid of a computer.

Botulinium Toxin (botox) may be offered which is small injection into the bladder wall of Botox to block some of the nerve impulses which occur in over active bladder so reducing the urgency and frequency.

Stress urinary incontinence is treated by teaching pelvic floor exercises. If this is unsuccessful then a referral is made to either a urogynaecologist or urologist for an assessment. An operation procedure of either a trans vaginal tape, or a transoburator tape, so stopping the leakage of urine by supporting the urethra or a colposuspension (which involves elevation of the bladder neck with sutures) can be offered.

If voiding difficulties have occurred due to a prolapse then this can be corrected by surgery or ring pessary.

Men with enlarged prostates who have voiding difficulties could be offered drug therapy or a trans urethral resection of the prostate (TURP)

APPENDIX 4

Relevant Information (Faecal incontinence)

High Risk Groups

People who report or are reported to have faecal incontinence should be offered care to be managed by healthcare professionals who have the relevant skills, training and experience and who work within an integrated continence service (Good practice in continence services, 2000).

High risk groups

- Frail older people
- People with loose stools or diarrhoea from any cause
- Women following childbirth (especially following third and fourth degree obstetric injury)
- People with neurological or spinal disease/injury (for example, spina bifida, stroke, multiple sclerosis, spinal cord injury)
- People with severe cognitive impairment
- People with urinary incontinence
- People with pelvic organ prolapse and/or rectal prolapse
- People who have had colonic resection or anal surgery
- People who have undergone pelvic radiotherapy
- People with perianal soreness, itching

Relevant Health History

The following aspects of the patient's health history must be taken into consideration:

- **Weight:** Excess weight can increase abdominal pressure during physical activity, which may increase risk of incontinence.
- **Obstetric History:** Risk factors for incontinence include weight of baby (over 8lb/4kg), trauma (episiotomy, tear), assisted delivery (forceps, suction), length of labour (long or short), epidural, number of babies, gaps between them (less than 2 years).
- **Surgery:** Previous surgery must be documented; particularly anal surgery.
- **Medical Conditions:** Many medical conditions can affect the function of the bowel. For example: neurological conditions: multiple sclerosis, diabetes, spinal injuries, stroke, dementia, back pain, chronic cough, depression, physical and learning disabilities. Also note any history of sexual abuse which must be acquired with due sensitivity. Allergies must be documented.
- **Constipation:** Severe constipation and straining at stool over a long period may cause changes in pelvic neurological function. Aim to investigate and treat the chronic constipation and review the patient following resolution of the constipation. (For further information regarding constipation, refer to the Trust Bowel Care Guidelines).

Initial management

Initial management should address the individual's bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time.

Healthcare professionals should explain that a combination of initial management interventions is likely to be needed. The specific management intervention(s) offered should be based on the findings from the baseline assessment, tailored to individual circumstances and adjusted to personal response and preference.

Diet

Healthcare professionals should recommend a diet that promotes an ideal stool consistency and predictable bowel emptying. This may be different for each patient.

When addressing food and fluid intake healthcare professionals should:

- take into account existing therapeutic diets
- ensure that overall nutrient intake is balanced
- consider a food and fluid diary to help establish a baseline
- advise patients to modify one food at a time if attempting to identify potentially contributory factors to their symptoms
- encourage people with hard stools and/or clinical dehydration to aim for at least 1.5 litres intake of fluid per day (unless contraindicated).
- consider the opportunity to screen for malnutrition, or risk of malnutrition[8].

Bowel habit

Healthcare professionals should address the individual's bowel habit, aiming for ideal stool consistency and satisfactory bowel emptying at a predictable time. A bowel habit intervention should contain the following elements:

- encouraging bowel emptying after a meal (to utilise the gastrocolic response)
- ensuring toilet facilities are private and comfortable and can be used in safety, with sufficient time allowed
- encouraging people to adopt a sitting position where possible while emptying the bowel (use of foot stool).
- teaching people techniques to facilitate bowel evacuation and stressing the importance of avoiding straining.
- Avoid distractions (reading etc)

Toilet access

- locations of toilets should be made clear to the individual where appropriate
- equipment to help people to gain access to a toilet should be provided advice should be given to people with faecal incontinence on easily removable clothing to reduce time needed for access
- if a person with faecal incontinence is dependent on others for access to the toilet, help should be readily available
- if appropriate, people with faecal incontinence should be referred to the relevant professionals for assessment of their home and/or mobility.
- strategies for planning routes for travel to facilitate access to public conveniences
- use of a toilet access card or RADAR key to allow access to 'disabled' toilets in the National Key Scheme.

Medications

When reviewing medication, healthcare professionals should consider alternatives to drugs that might be contributing to faecal incontinence.

Antidiarrhoeal medication should be offered to people with faecal incontinence associated with loose stools once other causes (such as excessive laxative use, dietary factors and other medication) have been excluded. Antidiarrhoeal medication should be prescribed in accordance with the summary of product characteristics.

The antidiarrhoeal drug of first choice should be loperamide hydrochloride. It can be used long term in doses from 0.5 mg to 16 mg per day as required. For doses under 2mg, loperamide hydrochloride syrup should be considered. People who are unable to tolerate loperamide hydrochloride should be offered codeine phosphate, or cophenotrope.

Loperamide hydrochloride should not be offered to people with:

- hard or infrequent stools
- acute diarrhoea without a diagnosed cause
- an acute flare-up of ulcerative colitis or infective colitis.

When loperamide hydrochloride is used:

- it should be introduced at a very low dose and the dose should be escalated, as tolerated by the individual, until the desired stool consistency has been achieved
- it should be taken as and when required by the individual
- the individual should be advised that they can adjust the dose and/or frequency up or down in response to stool consistency and their lifestyle.

Coping strategies

During assessment and initial management healthcare professionals should offer people with faecal incontinence advice on coping strategies including:

- the use of continence products and information about product choice, supply sources and use
- where to get emotional and psychological support, including counselling or psychological therapy, where appropriate, to foster acceptance and positive attitudes
- how to talk to friends and family about incontinence and its management.

Appliances

People with faecal incontinence should be offered:

- disposable body-worn pads in a choice of styles and designs and disposable bed pads if needed
- pads in quantities sufficient for the individual's continence needs. It is inappropriate to limit the number of pads given
- anal plugs (for people who can tolerate them)
- skin-care advice that covers both cleansing and barrier products
- advice on odour control and laundry needs
- disposable gloves, irrigation aids

The use of reusable absorbent products in the management of faecal incontinence is not generally recommended.

Review of treatment

After each intervention healthcare professionals should ask the person whether their faecal incontinence has improved. People continuing to experience symptoms should be:

- involved in discussions about further treatment options (including effectiveness and adverse effects) or alternative coping strategies
- asked if they wish to try further treatments.

Specialist assessment

The Trust employs a Colorectal Advanced Nurse Practitioner with specialist skills for endoanal ultrasound and anorectal physiology and conservative management strategies for incontinence including biofeedback and rectal irrigation. Patients with faecal incontinence that has not been resolved by simple measures above, then a referral to this service should be made

People with continuing faecal incontinence after specialised conservative management should be considered for specialist assessment, including:

- endoscopic examination as a baseline to exclude other pathology to account for symptoms
- anorectal physiology studies
- endoanal ultrasound and sometimes, magnetic resonance imaging,
- other tests, including MRI proctography, as indicated.

Specialised management

People who continue to have episodes of faecal incontinence after initial management should be considered for specialised management. This may involve referral from a specialist continence service to the Colorectal Advanced Nurse Practitioner.

Facilities available locally include:

- pelvic floor muscle training
- bowel retraining
- specialist dietary assessment and management
- biofeedback
- surgical interventions
- rectal irrigation

The Trust hopes to develop a service to offer electrical stimulation via percutaneous tibial nerve stimulation.

Some of these treatments might not be appropriate for people who are unable to understand and/or comply with instructions. For example, pelvic floor re-education programmes may not be appropriate for those with neurological or spinal disease/injury resulting in faecal incontinence.

Surgery

All people with faecal incontinence considering or being considered for surgery should be referred to a specialist surgeon to discuss:

- the surgical and non-surgical options appropriate for their individual circumstances

- the potential benefits and limitations of each option, with particular attention to longterm results
- realistic expectations of the effectiveness of any surgical procedures under consideration.

People with a full-length external anal sphincter defect that is 90° or greater (with or without an associated internal anal sphincter defect) and faecal incontinence that restricts quality of life should be considered for sphincter repair. People should be given a realistic expectation of what this operation can achieve and information about possible adverse events, in both the short and long term.

People with internal sphincter defects, pudendal nerve neuropathy, multiple defects, external sphincter atrophy, loose stools or irritable bowel syndrome should be informed that these factors are likely to decrease the effectiveness of anal sphincter repair. Success rate can be as low as 30%. People undergoing anal sphincter repair to manage their faecal incontinence should not routinely receive a temporary defunctioning stoma. People undergoing anal sphincter repair should not receive constipating agents in the post-operative period and should be allowed to eat and drink as soon as they feel able to.

A trial of temporary sacral nerve stimulation should be considered for people with faecal incontinence in whom sphincter surgery is deemed inappropriate. These may be patients with intact anal sphincters, or those with sphincter disruption. In those with a defect contraindications to direct repair may include atrophy, denervation, a small defect, absence of voluntary contraction, fragmentation of the sphincter or a poor quality muscle.

All individuals should be informed of the potential benefits and limitations of this procedure and should undergo a trial stimulation period of at least 2 weeks to determine if they are likely to benefit. People with faecal incontinence should be offered sacral nerve stimulation on the basis of their response to percutaneous nerve evaluation during specialist assessment, which is predictive of therapy success. People being considered for sacral nerve stimulation should be assessed and managed at a specialist tertiary centre with experience of performing this procedure.

If a trial of sacral nerve stimulation is unsuccessful, an individual can be considered for a neosphincter, for which the two options are a stimulated graciloplasty or an artificial anal sphincter. People should be informed of the potential benefits and limitations of both procedures. People offered these procedures should be informed that they may experience evacuatory disorders and/or serious infection, either of which may necessitate removal of the device.

People being considered for either procedure should be assessed and managed at a specialist centre with experience of performing these procedures. If an artificial anal sphincter is to be used, there are special arrangements that should be followed as indicated in NICE interventional procedures guidance and eligible patients should be referred to a specialist centre.

Antegrade irrigation via appendicostomy, neo-appendicostomy or continent colonic conduit may be considered in selected people with constipation and colonic motility disorders associated with faecal incontinence.

Sacral nerve stimulation and neosphincter surgery is not available within the Trust and people being considered for such procedures will be referred to an appropriate specialist centre. People who have an implanted sacral nerve stimulation device, stimulated graciloplasty or an artificial anal sphincter should be offered training and ongoing support at a specialist centre. These people should be monitored, have regular reviews and be given a point of contact.

A stoma should be considered for people with faecal incontinence that severely restricts lifestyle only once all appropriate non-surgical and surgical options, including those at specialist centres, have been considered. Individuals should be informed of the potential benefits, risks and long-term effects of this procedure. Individuals assessed as possible candidates for a stoma should be referred to a stoma care service.

Local clinical teams should work as appropriate with local and national organisations to:

- raise public awareness of the causes, prevalence and symptoms of faecal incontinence and the resources needed to treat it
- aid mutual support between people with faecal incontinence
- decrease the taboo surrounding faecal incontinence, and
- encourage people with faecal incontinence to seek appropriate help.

All staff working with people with faecal incontinence should be aware of both the physical and the emotional impact this condition can have on individuals and their carers.

Healthcare professionals should ensure that people with faecal incontinence and their carers:

- are kept fully informed about their condition and have access to appropriate sources of information in formats and languages suited to their individual requirements
- are offered access to or made aware of appropriate support groups (which may include alerting people with faecal incontinence to the possibility of family and friends having similar experiences, or suggesting community groups or more formal organisations). Consideration should be given to the individual's cognition, gender, physical needs, culture and stage of life

Management of specific groups

Healthcare professionals should take a proactive approach to bowel management for specific groups of people:

- people with faecal loading or constipation
- people with limited mobility
- hospitalised patients who are acutely unwell and develop acute faecal loading and associated incontinence
- people with cognitive or behavioural issues
- people with neurological or spinal disease/injury resulting in faecal incontinence
- people with learning disabilities
- severely or terminally ill people
- people with acquired brain injury.

People with faecal loading

People in whom acute severe faecal loading is identified as contributing to faecal incontinence should initially be offered a rectally administered treatment to satisfactorily clear the bowel. Often treatment will need to be repeated daily for a few days, depending on tolerance and on whether satisfactory bowel clearance is achieved. If rectal interventions are not appropriate or fail to satisfactorily clear the bowel, and bowel obstruction has been excluded as possible cause, a potent oral laxative should be offered. People should be informed that oral laxatives may cause griping abdominal pain, loose stools and prolonged bowel activity. Toilet access should be ensured. Healthcare professionals involved in the management of faecal incontinence associated with chronic on-going faecal loading/impaction should aim to reduce the chance of recurrence by recommending a combination of initial management options tailored to the individual. If this fails, the use of orally administered laxatives to promote bowel emptying should be considered. Rectally administered preparations should be used if oral laxatives cause episodes of faecal incontinence and there is a need to produce planned bowel evacuations.

People with limited mobility

People with limited mobility who continue to have episodes of faecal incontinence after initial management should be offered a regimen that will produce a planned, predicted bowel action when carers are present if needed. This may be achieved by a combination of oral or rectal laxatives and/or constipating agents. This regimen should also consider:

- toilet access.
- appropriate disposable products
- that the stool needs to be in the rectum at the time of the planned bowel action.

People using enteral tube feeding and reporting faecal incontinence

Healthcare professionals should ensure that people with faecal incontinence who are receiving enteral tube feeding have their type and timing of feed modified on an individual basis to establish the most effective way to manage faecal incontinence.

People with severe cognitive impairment

If baseline assessment and initial management have failed to resolve faecal incontinence, people with confirmed severe cognitive impairment should be referred for a behavioural and functional analysis to determine if there is any behavioural reason for faecal incontinence. Following analysis, people should be offered cause-specific interventions founded on structured goal planning that aim to resolve as well as manage behavioural aspects that may be contributing to faecal incontinence. In cases of severe cognitive impairment, further specialist management of faecal incontinence may be inappropriate.

People with neurological or spinal disease/injury

People with neurological or spinal disease/injury resulting in faecal incontinence who continue to have episodes of faecal incontinence after initial management should be offered a neurological bowel management programme. This aims to achieve a predictable routine and avoid faecal incontinence and severe constipation.

Management should involve progressing through the following steps until satisfactory bowel habit is established:

- ascertaining individual preferences
- ascertaining premorbid bowel habit, if possible

- maximising the individual's understanding of normal bowel function and how it has been altered
- modifying diet and/or administering rectal evacuants and/or oral laxatives, adjusted to individual response, to attempt to establish a predictable pattern of bowel evacuation
- consideration of digital anorectal stimulation for people with spinal cord injuries or other neurogenic bowel disorders
- consideration of manual/digital removal of faeces, particularly for people with a lower spinal injury, if there is a hard plug of faeces in the rectum, presence of faecal impaction, incomplete defaecation, an inability to defaecate and/or all other bowel-emptying techniques have failed to achieve bowel emptying and continence within a time acceptable to the individual.

Healthcare professionals should discuss the following management options with people unable to achieve reliable bowel continence after a neurological bowel management programme:

- coping and long-term management strategies for symptomatic individuals.
- rectal irrigation if appropriate
- other surgical options (including stoma) if faecal incontinence or the time taken for bowel emptying imposes major limits on their lifestyle.

People with learning disabilities

People with learning disabilities may have had faecal incontinence from childhood. Others may experience faecal incontinence for the first time in adulthood. It is essential that these individuals follow the same initial care pathway as other people with faecal incontinence. They may require additional support during assessment and management to achieve equal outcomes.

Severely or terminally ill people

Healthcare professionals should consider a faecal collection device for people in intensive care settings and people receiving palliative care with faecal incontinence and associated loose stools.

APPENDIX 5

Product Name	Illustration	NHSS C Code	Working Absorbency	Inner Packaging	Price per Piece	Comment
Light incontinence – To be worn with patients own underwear						
TENA COMFORT Mini Extra		CFP 1067	250mls	28	10p	For light urinary incontinence
TENA COMFORT Mini Super		CFP 336	400mls	28	14p	Light to moderate incontinence
Shaped pads – to be used with fixation pants						
TENA COMFORT Plus		CFQ 800	650mls	46	19p	Moderate to heavy urinary incontinence use, also suitable for faecal incontinence
TENA COMFORT Extra		CRQ 801	800mls	40	21p	For the management of heavy urinary incontinence and moderate faecal soiling

Size	NHSC Code	Cost
Fixation Pants – for use with shaped pads (Euron Net Ultra)		
Medium	CFP 232	Packet of 25 £3.79
Large	CFP 238	Packet of 25 £4.01
Extra Large	CFP 387	Packet of 25 £4.86

Product Name	Illustration	NHSSC Code	Working Absorbency	Inner Packaging	Cost	Comment
Belted products – measure hip size for accurate fit. Suitable for bed-bound/chair bound/hoisted patients						
TENA FLEX PLUS Small 60-90cm		CFP 1238	700mls	30	37p	Moderate to heavy incontinence use
TENA FLEX PLUS Medium 70-110cm		CFP 1251	750mls		39p	
TENA FLEX		CFP	900mls		44p	

PLUS Large 85-125cm		1239				
TENA FLEX PLUS Extra Large 105-155cm		CFP 1240	1100mls		64p	