Family Nursing & Home Care

Urinary Incontinence Management and Continence Promotion for Adults

3 March 2022

Document Profile

Document Registration	Added following ratification
Type	Policy and Procedures
Title	Urinary Incontinence Management and Continence Promotion for Adults
Author	Fiona Le Ber
Category **clinical / corporate / education / Health & Safety / HR / Info Governance**	Clinical
Description	This policy / guideline will educate and support clinical staff to promote continence and manage incontinence in an effective and comprehensive way. It will also set out the criteria for provision of incontinence aids from the Government of Jersey Subsidised product Scheme
Approval Route	Organisational Governance Approval Group
Approved by	Rosemarie Finley
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Version control / changes made

Date	Version	Summary of changes made	Author
01.11.21	1	New policy	Fiona Le Ber

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1. INTRODUCTION

1.1 Rationale

“Continence is the ability to pass urine or faeces voluntarily in a socially acceptable place.

A person needs to be able to:

- recognise the need to void
- identify the correct place to void
- reach the toilet
- hold on until the toilet is reached
- pass urine or faeces once there

Incontinence is the unwanted and involuntary leakage of urine or stool or wind. Many people, will be affected by incontinence at some point in their life”. (RCN 2021)

Incontinence is not a disease but a symptom of an underlying condition. Through assessment and investigation by a suitably trained professional, individuals suffering from incontinence may have their symptoms resolved, improved or managed in the most appropriate way, **without** the need for supply of continence products. Continence assessment is essential, as treatment for continence is dependent on the cause. (NHS 2018).

Adult incontinence can affect a person’s self-confidence, loss of independence, relationships and employment prospects and can subsequently cause depression. In older people, incontinence can be a contributing factor in skin breakdown, falls and urine infection, which in turn often causes confusion.

Poor continence care is also associated with the development of pressure ulcers. (NHS 2018).

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.

1.2 Scope

This policy applies to all clinical staff within Adult Services at Family Nursing & Home Care (FNHC) who provide continence care to adult patients. It will also set out the criteria for provision of incontinence aids from the Government of Jersey Subsidised product Scheme.

It should be read in conjunction with the FNHC/HCS polices:

- Guidelines and Standard Operating Procedure’s The Management of Urinary Catheterisation (Adults)
- Island Wide pressure ulcer framework
- UTI assessment tool – awaiting launch

1.3 Role and Responsibilities

The Chief Executive (CEO)

The CEO has overall responsibility for effective management of risk within the organisation. As accountable officer, the CEO is responsible for the effectiveness of the organisation's systems of internal controls.

Operational Leads

Operational leads have responsibility for ensuring that the required structures and resources are in place to enable effective care for patients requiring Continence care/ assessment.

Team Leaders

Team leaders have responsibility to ensure that their staff:

- know when it is appropriate to carry out continence assessment and provide subsidised products
- know how to seek advice/guidance
- are trained and have the competencies needed to undertake all elements of continence assessment for which they are required to undertake (Appendix 1)
- have awareness and access to this document

Clinical Nurse Specialist

The Clinical Nurse Specialist has responsibility to:

- Act as a resource for healthcare professionals in the pursuit of therapeutic continence care delivery
- Develop clinical care pathways and practice guidelines using best evidence where it exists; ensuring that they are implemented, regularly updated and available to relevant staff
- Monitor quality through clinical audit, taking into account comments and complaints
- Work in partnership with other organisations (Commissioners; Health & Community Services; other statutory and voluntary organisations)
- Provide educational support and training programmes to the multidisciplinary team
- Deliver high quality and cost effective services.
- Provide an education network of 'Continence Resource / Link Nurses'
- Hold current literature on the promotion of continence and management of incontinence.

Clinical Staff

Clinical staff have responsibility for:

- establishing the patient's needs for a bowel and bladder assessment, during their initial holistic assessment to FNHC
- ensuring they carry out continence assessments which they have received training and have been deemed competent unless it is being carried out as part of that training or competency assessment, in which case they must be accompanied by a competent colleague
- completing correct documentation for continence assessment

2. POLICY

Students in practice, may undertake continence assessment provided they are accompanied by a competent member of staff at all times.

If delegating any aspect of continence assessment to un-registered staff, nurses must ensure they have been trained and deemed competent in the task.

All health care professionals have a responsibility to adopt best practice when caring for patients with incontinence.

The involvement during a clinical examination, consultation or treatment must be the clearly expressed choice of a patient.

All opportunities should be taken to promote continence and a healthy bladder and bowel among people and the wider community

Health Care professionals should identify and record any preferences or objections resulting from diverse religious, cultural or ethnic backgrounds as early as possible to avoid the potential for causing offence.

If it is the patient's choice, a suitable chaperone should be present. Record the presence of the chaperone and their name in the patient's healthcare record.

Seek and record the patient's consent to have relatives or carers present during examinations or procedures.

Record in the patient's healthcare record whether they have declined an assessment/procedure at any point during the process.

2.1 Referral Criteria

Housebound and residential home patients aged over 18, may be referred by to the Adult District Nursing Services for continence care. Nursing Home patients remain the responsibility of Nurse in the Care Home however they may ask for support / advice from the Adult District Nursing Services or the Community CNS.

Non housebound patients should be referred to the Urology Department at HCS. See GP's Referral Pathway for female patients with continence issues / bladder symptoms (appendix 2)

Referrals to the Clinical Nurse Specialist (CNS) should be discussed with FNHC CNS. Referrals to the Urology Clinical Nurse Specialist (CNS) at HCS should be discussed with FNHC CNS first. The patient will be assessed for eligibility and acuity.

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

If a patient is in hospital it is the expectation that an assessment will be undertaken prior to discharge if incontinence is unresolved. A continence assessment must be made a priority issue prior to discharge. (ACA 2021)

2.2 Transition

Transition of a young person's care from paediatric to adult services can be stressful for both the young person and their parents and carers. It is therefore important that it is a sensitively managed process, not an event.

The process should begin with planning the move from children's to adults' services at the same time as moving from secondary schooling. (NICE 2016)

It should include ensuring that a young person, who has moved from children's to adults' services, but does not attend their first meeting or appointment, are contacted by adult services and given further opportunities to engage (NHS 2018)

3. PROCEDURE

3.1 Assessment

Following receipt of any referral, a holistic assessment will be undertaken for all patients. If continence is identified as an issue then a continence assessment must be completed.

Patients, or their carer/advocate, should be asked to complete a symptom/ bladder diary for the appropriate period of time, (Appendix 3)

Encourage patient to complete a minimum of 3 days of the diary covering variations in their usual activities, such as both working and leisure days (NICE 2019)

If the patient is currently using pads and is unable to measure urine output then the used pads must be weighed. This will accurately assess the degree of incontinence and therefore enable the health care professional to prescribe products that will meet the client's needs.

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.

Medical conditions associated with incontinence

Infection - not only of the urine but also of the skin between the legs, the commonest of which is a fungal infection in which the skin is red and moist.

Oestrogen deficiency - very common in elderly ladies, causing urinary urgency and a sore, dry vagina.

Diabetes - often associated with incontinence. Check for the presence of glucose in the urine.

Neurological disorders such as stroke or multiple sclerosis - affect central nervous system control of bladder and sphincter. (BSG 2019)

Previous pregnancies - difficult deliveries, may result in prolapse or nerve damage.

Initial Continence Assessment will utilise The Colley Model (appendix 4) and must include:

- history
- patient goals and expectation of treatment
- physical examination (consider prolapse, vaginal dryness, colour , abnormalities, oedema, tight foreskin)
- symptom diary
- urinalysis if under 65
- post-void urine measurement (use of Bladder scanner)
- medication review
- assessment of skin integrity
- changes to symptoms, comorbidities, lifestyle, mobility, medication, BMI, and social and environmental factors
- the suitability of alternative treatment options
- the efficacy of the absorbent containment product currently used and the quantities used (NICE 2019)
- Is the patient depressed leading to demotivation?
- Is the patient anxious increasing urinary urgency and frequency?
- Is the incontinence worsened by, or causing, anxiety/depression? (BSG 2018)

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. Incontinence can be often treated with simple lifestyle changes but it may also need more invasive treatments including surgery.

Lifestyle interventions may include a trial of caffeine reduction to patients with overactive bladder. Consider advising patients with urinary incontinence or overactive bladder and a high or low fluid intake to modify their fluid intake.

Advise patients with urinary incontinence or overactive bladder who have a BMI greater than 30 to lose weight. (NICE 2019)

For faecal incontinence, please refer to the FNHC Bowel Care Policy and Procedures for Adults.

Urinalysis

Urinalysis is a key part of any Continence Assessment. New onset incontinence could be linked to an undiagnosed urinary tract infection.

Urinalysis gives us further information to help assess patients holistically and diagnose and treat type or types of urinary incontinence, and contributing factors such as undiagnosed diabetes, or haematuria suggesting a possible underlying bladder cancer.

Urinalysis detects the presence of bacteria in the urine by detecting Leucocytes and Nitrates. Leucocytes are white blood cells produced by the body to fight bacteria and Nitrates are enzymes produced by bacteria.

Urinalysis as a diagnostic tool for urinary tract infections, should only be used for adults in their own homes, **under the age of 65**, as the chances of asymptomatic bacteriuria are lower, meaning urinalysis becomes a more useful diagnostic tool.

However, the National Institute for Health and Care Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN) now recommended that urinalysis is NOT used to diagnose a urinary tract infection in in those over 65 years or living in residential or nursing homes and in people with long term indwelling urinary catheters. Instead, a diagnosis must be made purely on a clinical assessment of signs and symptoms. (RCN 2021). (Appendix 5) The use of the Care Home & Community UTI Assessment Tool (Appendix 6) should be used if a UTI is suspected.

The main causes of urinary incontinence are:

Urge incontinence (detrusor over activity). In this condition the patient is unable to prevent involuntary bladder contractions, which cause urgency with little or no warning of incontinence. The sufferer may respond to this urgency by frequent visits to the toilet day and night. Urge incontinence is often made worse by anxiety or fast bladder filling, for example after diuretic medications.

Stress incontinence (pelvic floor weakness). A small leakage of urine occurs on physical exertion such as standing, lifting, coughing or sneezing, and rarely occurs during sleep at night. This is the commonest cause of incontinence in middle aged women and is seen in some men after prostatectomy.

Overflow incontinence (retention of urine). The patient will have a large post-void residual urine volume and may complain of continuous dribbling incontinence or symptoms like stress incontinence. Recurrent urinary tract infections are common and the condition is made worse by constipation or anticholinergic medication. Overflow incontinence can be caused by diabetes and some types of nerve damage. It also occurs in men with prostatic obstruction.

Outflow obstruction. This almost always occurs in men, who may complain of difficulty in starting micturition, poor urinary stream and dribble after micturition, perhaps with a feeling of inadequate emptying.

Functional incontinence (e.g. poor or painful mobility, loss of dexterity, impaired communication, mental confusion and depression). Incontinence is due to inability to reach and use the toilet. (BSG 2018)

Nocturnal enuresis - involuntary loss of urine during sleep

Neurogenic bladder dysfunction - urinary bladder problems due to disease or injury of the central nervous system or peripheral nerves involved in the control of urination (RCN 2021)

Conservative Treatment measures by the District Nurse will include:

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

A treatment/management plan should be agreed with the patient and a copy given to them (DOH 2000). (Appendix 7).The registered healthcare professional remains accountable for the initial assessment of continence and instigation of first line treatment, such as fluid and continence promotion advice.

Aids and adaptations:

Before containment products are issued, the benefits of available aids and appliances must be considered to manage incontinence to ensure patient's dignity. For example;

- Commodes
- Male Urinals/ Female urinals
- Bed pans
- Drainage funnels
- Penile sheaths – male patients only
- Increase oral fluid intake (see fluid matrix appendix 8)

In addition to this consideration should also be given to:

- Environmental changes
- Clothing adaptation
- Carer input

The health care professional should not offer absorbent containment products, hand-held urinals or toileting aids unless other treatment options have been explored (NICE 2019).

Eligibility to receive provision of body worn Incontinence Products

The Community CNS along with the Subsidised Products Scheme panel have overall responsibility for the provision and supply of continence products.

Each patient must have an assessment by health care professionals and an annual reassessment in order to be entitled to subsidised products (appendix).(ACA 2021)

Continence Product Provision

Absorbent pads will not be supplied before the individual person has undergone a complete continence assessment / yearly reassessment. Exceptions to this are for individuals at the end of life.

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

Patient's that have a pad weight of less than 200mls will not be eligible for products.

The number of absorbent pads issued per 24 hours would normally not exceed 4, but provision should meet assessed clinical need. "All in one" products will only be provided to clients with a severe physical or mental impairment.

For patients who struggle with the fixation pants and pad e.g. patients suffering with dementia or learning disabilities Tena pull up pants may be prescribed with a maximum of 3 pairs in 24 hours (these are not recommended for night time use). 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.

Washable products are suitable and advisable as a first line consideration for adults with moderate urinary incontinence. They are not suitable for people with faecal incontinence. Disposable products should not be worn at the same time as washable pants.

Accountability

The clinician who assesses an individual to provide an absorbent pad is accountable for that decision; and needs to ensure that the chosen pad is fit for purpose and safe to use at the time of assessment.

There is a responsibility for the patient and/or carer to request a reassessment if their needs change or yearly.

The patient or carer should be advised on how to apply/use the product and be given sufficient information and training in the safe use of the product.

The clinician must also ensure the assessment for a suitable absorbent pad takes account of the environment(s). For example, the assessment should consider what would be suitable if the patient is soon to be transferring between care settings from areas of high carer support to lower levels of carer support (such as on discharge from a hospital or nursing care setting, to their own home or supported living). The rationale is that a pad that may be deemed suitable in a facility where there is 24 hour nursing or carer support may not be suitable to meet the needs of that patient in the environment of their own home, where they may have little or no support

Absorbent pads should not be supplied for treatable medical conditions (or for bodily fluids other than urine or faeces). The 'custom and practice' of automatically providing products to adults (including those with an acknowledged disability) is not appropriate and could be considered discriminatory. If an individual has capacity and declines treatment, provision of pads will not be offered as an alternative (ACA 2020).

If using incontinence pads please refer to the Acute Product Selection Guide: Continence Pads (Appendix 9).

Incontinence pads contain superabsorbent polymer gel granules and there is a risk of death or severe harm if these are ingested (NHS Improvement 2017). Staff should ensure they are aware of the Patient Safety alert "Risk of Death and Severe Harm from ingesting superabsorbent polymer gel granules" (Appendix 10) and use this information when assessing patient suitability for containment products.

4. CONSULTATION PROCESS

Name	Title	Date
Lucy Henderson	Urology & Continence Lead Nurse HCS	11.11.21
Rui Cas		
Tracey Blackmore		
Benjamin Hughes	Urology Consultant	12.11.21
Elspeth Snowie	Clinical Effectiveness Facilitator	29.10.21
Tia Hall	Operational lead Adult Services /Registered Manager District nursing service	
Joanna Champion	District Nurse Team Leader	
Jessica Clarke	District Nurse Team Leader	
Angela Stewart	District Nurse Team Leader	
Michelle Margetts	District Nurse Team Leader	
Gilly Glendewar	Tissue Viability Nurse	
Sandra Lamb	Community Staff Nurse	12.11.21
Anne Morgan	Deputy Sister District Nurse Team	11.11.21
Maureen De Gruchy	Quality Performance and Development Nurse	01.11.21

5. IMPLEMENTATION PLAN

Action	Responsible Person	Planned timeline
Email to staff	Education and Development Secretary/Administrative Assistant	Within two weeks of ratification
Policy to be placed on Procedural Document Library	Education and Development Secretary/Administrative Assistant	Within two weeks of ratification
Staff to sign up to documents if relevant	Operational Leads	Within two weeks of ratification

6. MONITORING COMPLIANCE

Team Leaders can monitor opportunistically when reviewing clinical care provision. The use of quality assurance tools such as audit may be considered.

7. EQUALITY IMPACT STATEMENT

Family Nursing & Home Care is committed to ensuring that, as far as is reasonably practicable, the way services are provided to the public and the way staff are treated reflects their individual needs and does not discriminate against individuals or groups on any grounds.

This policy document forms part of a commitment to create a positive culture of respect for all individuals including staff, patients, their families and carers as well as community partners. The intention is to identify, remove or minimise discriminatory practice in the areas of race, disability, gender, sexual orientation, age and 'religion, belief, faith and spirituality' as well as to promote positive practice and value the diversity of all individuals and communities.

The Family Nursing & Home Care values underpin everything done in the name of the organisation. They are manifest in the behaviours employees display. The organisation is committed to promoting a culture founded on these values.

Always:

- ✓ Putting patients first
- ✓ Keeping people safe
- ✓ Have courage and commitment to do the right thing
- ✓ Be accountable, take responsibility and own your actions
- ✓ Listen actively
- ✓ Check for understanding when you communicate
- ✓ Be respectful and treat people with dignity
- ✓ Work as a team

This policy should be read and implemented with the Organisational Values in mind at all times. See Appendix 11 for the Equality Impact Assessment for this Policy.

8. GLOSSARY OF TERMS

MEDICAL FACTORS;

Urinary History: To include storage symptoms such as frequency, nocturia, urgency, stress incontinence and leakage. Also voiding symptoms such as hesitancy, straining to void and poor or intermittent urinary stream. Any post micturition symptoms such as dribbling or a feeling of incompletely emptying of the bladder.

Bowel History: To include symptoms of storage such as diarrhoea, urgency to defecate, frequency and soiling. Also voiding symptoms such as constipation, flatulence, straining and feeling of incompletely emptying the bowel. Also consider rectal bleeding, change in bowel habit, painful evacuation, how many unsuccessful attempts at defecation, and whether the patient digitally assists their evacuation.

Relevant Medical Conditions:

To include condition which may exacerbate or co-exist with urinary or faecal incontinence such as disorders of the neurological system (e.g. multiple sclerosis, spinal cord injury, Parkinson's disease, cerebral vascular accident or pelvic deformities or injury. Also consider metabolic disorders such as diabetes, and disorders of the cardio respiratory and renal system.

SURGICAL FACTORS:

To include previous surgery for spinal conditions, low rectal surgery, sympathectomy or complex pelvic surgery. Consider any other treatment which may interfere with the normal support mechanisms of the vagina or urethra such as the application of a full leg plaster or a hernia support.

OBSTETRIC/ GYNAECOLOGICAL FACTORS:

To include the number and type of deliveries and their outcome; the menstrual history, and the menopausal status. An enquiry to be made into the symptoms of uterovaginal prolapse. The woman's sexual function, her expectations for this and for future childbearing will need to be discussed.

DRUG/ ALCOHOL FACTORS:

Some medications may be associated with urinary incontinence and may need to be reviewed. These include sedatives, hypnotics and smooth muscle relaxants. Drugs which affect fluid balance such as diuretics or alcohol need to be documented. Some drugs which affect the autonomic nervous system may affect bowel or bladder tone or function. Drug history will need to include any allergies which may affect treatment options. Also record any laxatives used and whether the patient is compliant with their drug prescription.

GENERAL ASSESSMENT:

The social and functional impact of urinary or faecal incontinence.

Environmental factors, dexterity, personal relationships, occupation, lifestyle factors such as smoking or obesity.

PHYSICAL FACTORS:

Examination may reveal an enlarged bladder or pelvic mass. Uterine, ovarian or prostate enlargement, rectal prolapse or anal sphincter dysfunction. Are haemorrhoids present or is there an anal fissure or tear. Also obvious discomfort may indicate a pelvic infection or atrophic changes. Loss of sacral sensation may indicate neurological disease. Bladder scan may be indicated at this stage.

MENTAL HEALTH/ COGNITIVE IMPAIRMENT:

This section is to include level of understanding or memory function. Underlying psychological problems or known psychiatric conditions. Levels of anxiety and depression may need to be considered. If the patient has carers, examine the availability and frequency of support available.

PATIENTS UNDERSTANDING OF CONDITION:

To include how the patient manages their incontinence such as route planning. Look at the impact of the problem on the patient's lifestyle and how their social life is affected.

CONTINENCE AIDS USED/ LEVEL OF MANAGEMENT:

The availability and cost of aids may be addressed, how aids are used and the level of success in managing the incontinence. It may be relevant, at this stage, to determine the patient's expectations.

(Montgomery 2019)

9. REFERENCES

Association for Continence Advice (ACA) (2021) Guidance for the provision of absorbent pads for adult incontinence A consensus document 2021 available at https://www.aca.uk.com/application/files/8216/2220/2409/Product_Guidance_April_2021.pdf

British Geriatrics Society (BSG). 2018. Continence Care in Residential and Nursing Homes. Available at https://www.bgs.org.uk/resources/continence-care-in-residential-and-nursing-homes

Montgomery, L. Bowden, G. 2019 *Integrated Continence Policy for adults and children Including assessment, treatment and management in the acute and community setting.* Available at https://www.qegateshead.nhs.uk/sites/default/files/users/user10/OP51%20Integrated%20Continence%20Policy%20for%20Adults%20and%20Children.pdf

NICE 2019 *Urinary incontinence and pelvic organ prolapse in women: management.* available at https://www.nice.org.uk/guidance/ng123/chapter/Recommendations#assessing-urinary-incontinence

NICE 2016 'Transition from children's to adults' services for young people using health or social care services' and the subsequent Quality Standard53. Available at https://www.nice.org.uk/guidance/ng43

NHS England .2018. *EXCELLENCE in Continence Care Practical guidance for commissioners, and leaders in health and social care.* available at https://www.england.nhs.uk/wp-content/uploads/2018/07/excellence-in-continence-care.pdf

10. APPENDIX

Appendix 1 Competency Template

Level 1 Foundation	The practitioner performs skills under direct supervision of others more proficient in the skill
Level 2 Intermediate	The practitioner can demonstrate acceptable performance in the skill requiring less supervision and guidance but they are not expected to demonstrate full competence or practice autonomously
Level 3 Proficient	The practitioner demonstrates competency consistently throughout. They demonstrate the ability to practice safely and effectively without the need for direct supervision
Level 4 Advanced	The advanced practitioner is autonomous and reflexive, performs skills safely and accurately and is aware of current best practice
Level 5 Expert	The expert practitioner is able to demonstrate a deeper understanding of the skill and contributes to the development and dissemination of knowledge through teaching and development of others

Competency Document for Continence Assessment

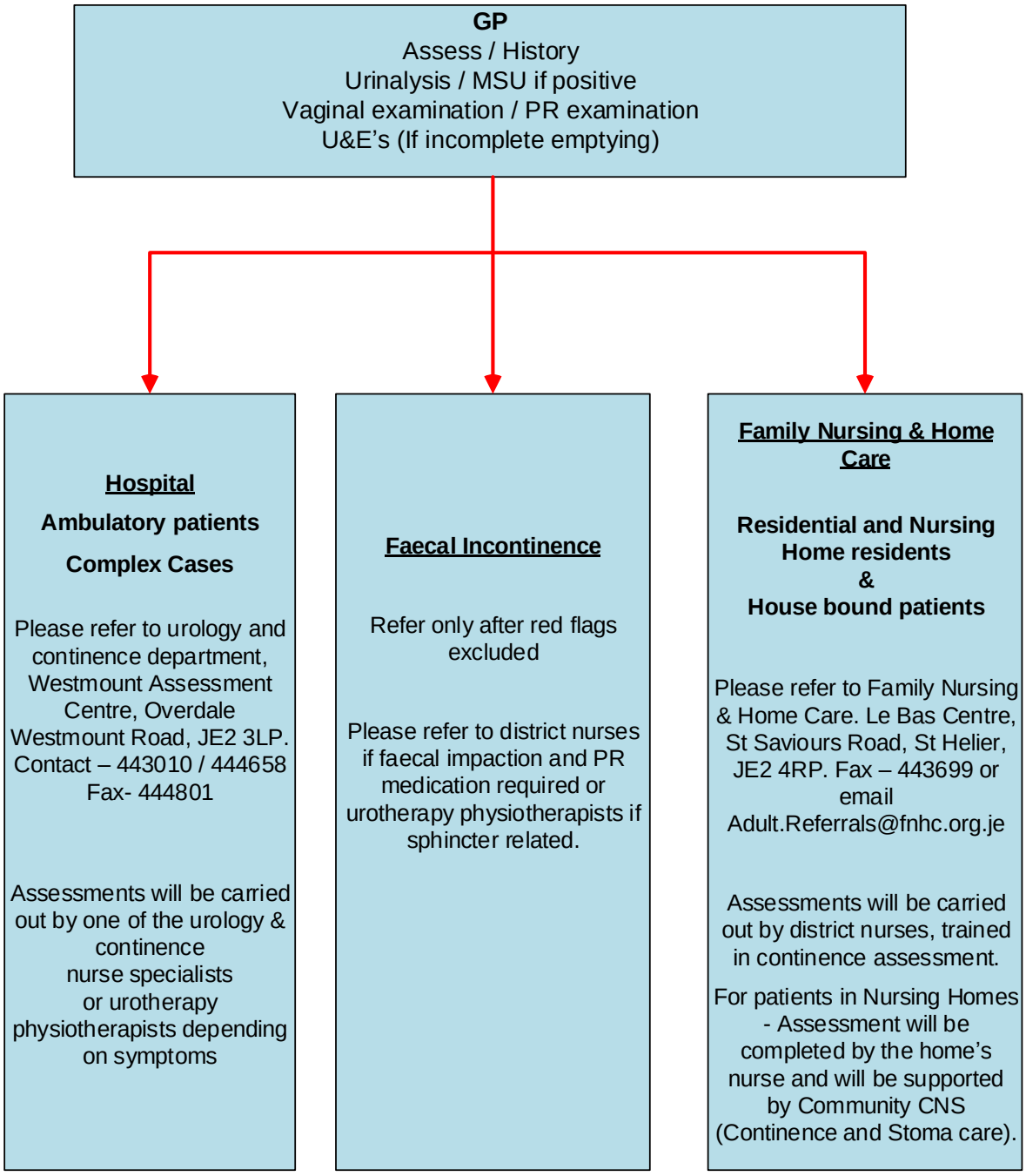
Name of Training Attended			
Date Attended		**Duration of Training**	
Training Provider			
Type of Training			
Main areas covered			
Outcome of Discussion re Knowledge Gained (e.g. key learning; questions asked/answers)	Assess knowledge of the following: • effective lifestyle interventions and appropriate timing of onward referral • red flag signs and symptoms • effects of medications on the lower urinary tract • impact of lifestyle modifications eg fluid intake, bowel management, caffeine reduction, weight reduction, smoking cessation • continence aids and products		

Criteria	**Self-Assessment**	**Assessment 1**	**Assessment 2**
1. Assessment	Date:	Date:	Date:
Obtain a basic history about continence status from the patient and assess symptom bother and desire for treatment			
Perform examination of the patient's abdomen for palpable mass or urinary retention			
Perform examination of the perineum to identify excoriation/prolapse/oestrogen deficiency			
If indicated, perform rectal examination to exclude faecal impaction			
Identify 'red flag' symptoms and manage or refer appropriately			
Undertake a functional assessment of mobility, manual dexterity and environment			

Criteria	Self-Assessment	Assessment 1	Assessment 2
2. Basic Investigations	Date:	Date:	Date:
Perform and interpret dipstick testing of urine and know when to send MSU			
Administer, explain and interpret bladder diaries			
Perform a bladder scan to assess post-void residual and interpret results, act upon the findings including onward referral when appropriate			
3. Initial management			
Develop a treatment plan and agree this with the patient (and/or carers when appropriate) based on initial assessment and basic investigations			
Explain bladder diary findings to patient and give advice based on findings			
Counsel patients in the correct use of continence aids and products			
Where indicated, initiate pelvic floor muscle training programme and allow 6-12 weeks for optimal treatment			
4. Reviewing the outcome of treatment			
Assess the response to lifestyle interventions and continence aids, referencing back to objectives agreed at initial assessment			
Recognise own level of responsibility and initiate appropriate onward referral			
Signature			

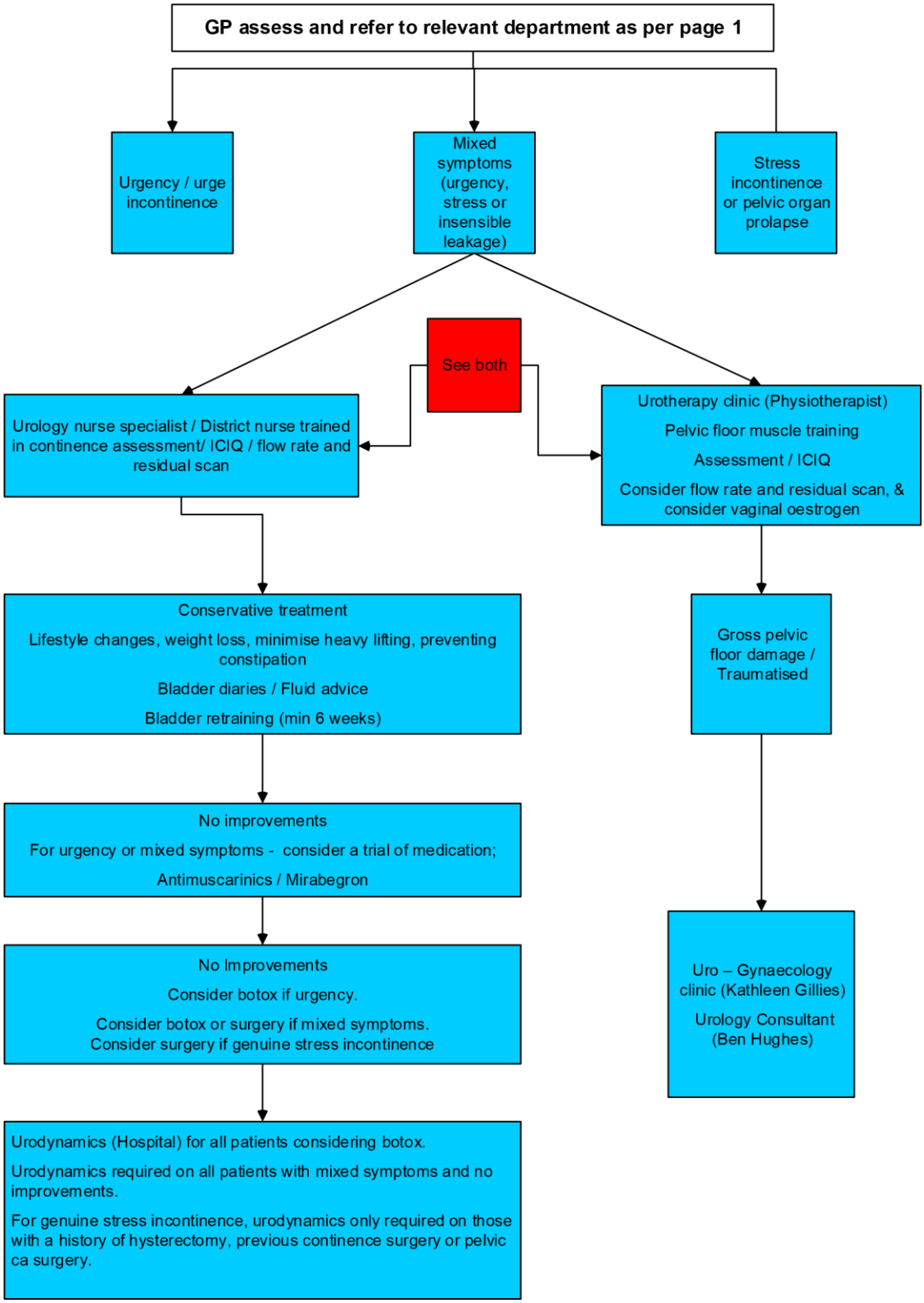
Following the second assessment, the assessee can be deemed competent if all criteria are achieved. **Date deemed competent:**
Assessor signature:
Assessee signature:
Comments:

Appendix 2 GP Referral Pathway for Female Patients with Continence Issues/Bladder Symptoms



The Continence Services (Hospital or Family Nursing) will refer to the relevant Health Care Professional as required – Please see * pathway for female patients with bladder symptoms or pelvic organ prolapse, page 2*

Pathway for female patients with continence issues / bladder symptoms or pelvic organ prolapse

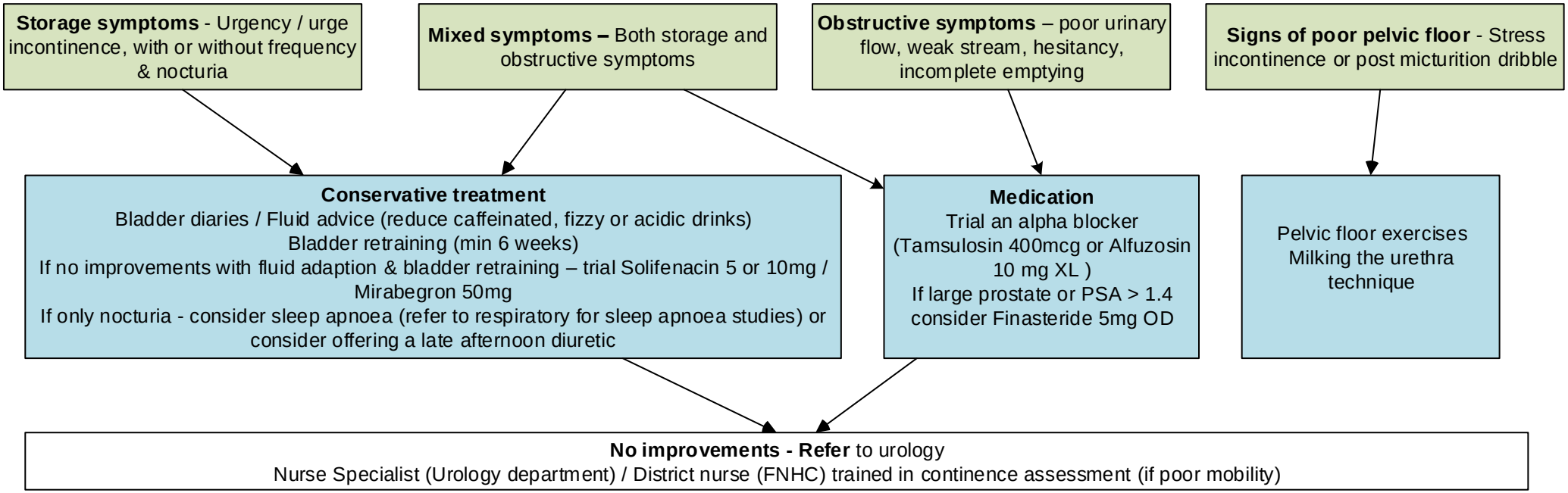


GP Pathway for MALE patients with LUTS

Refer direct to Urology Consultant (Mr Hughes) if any of the following;
Haematuria (request renal tract USS at referral)
PSA elevated for age / DRE abnormal
Recurrent urine infections (Over age of 60 yrs)

Refer to separate guidelines for all of the above

General Practitioner -
Obtain history to define symptoms
Urinalysis / MSU if positive
Digital rectal examination (assess prostrate – hard or soft)
IPSS urinary symptom questionnaire
Request USS & U&E's (If incomplete emptying / rec urine infections)



Appendix 3 Bladder Record Chart – Volume and Frequency

Name: **Date:**

Day 1				Day 2				Day 3			
Time	**Drinks**	**Quantity of urine passed (ml)**	**Did you leak before you went to the toilet?**	**Time**	**Drinks**	**Quantity of urine passed (ml)**	**Did you leak before you went to the toilet?**	**Time**	**Drinks**	**Quantity of urine passed (ml)**	**Did you leak before you went to the toilet?**
Example:											
7.30am	Tea/200ml	100ml	✓								

Instructions

Please read carefully

This chart is designed to help assess how your bladder functions both at home and at work. By filling this form in correctly you will help us accurately diagnose your condition.

The column marked ‘time’ refers to the daytime starting and finishing at 6.00 am in the morning. The chart should be filled in over a minimum of 3 days. For each day there are three columns.

Drinks

In this column you record how much fluid you drink, i.e. coffee, tea, water, alcohol etc.

Each time you have a drink you record how much you have drunk against the corresponding hour of the day. You may find it easier to measure how much a cup or mug holds (in ml) and estimate the fluid drank by always using the same cup.

Quantity of urine passed (ml)

In this column you record the amount or volume of urine passed.

Each time you pass urine, record the volume of urine (in ml) passed. For this you will need to buy a small plastic measuring jug – available from a chemist or from some supermarkets. Please also record during the night.

Where it is not possible to measure the volume, for example if you are out shopping, please tick the box to show that you have passed urine.

Did you leak before you went to the toilet?

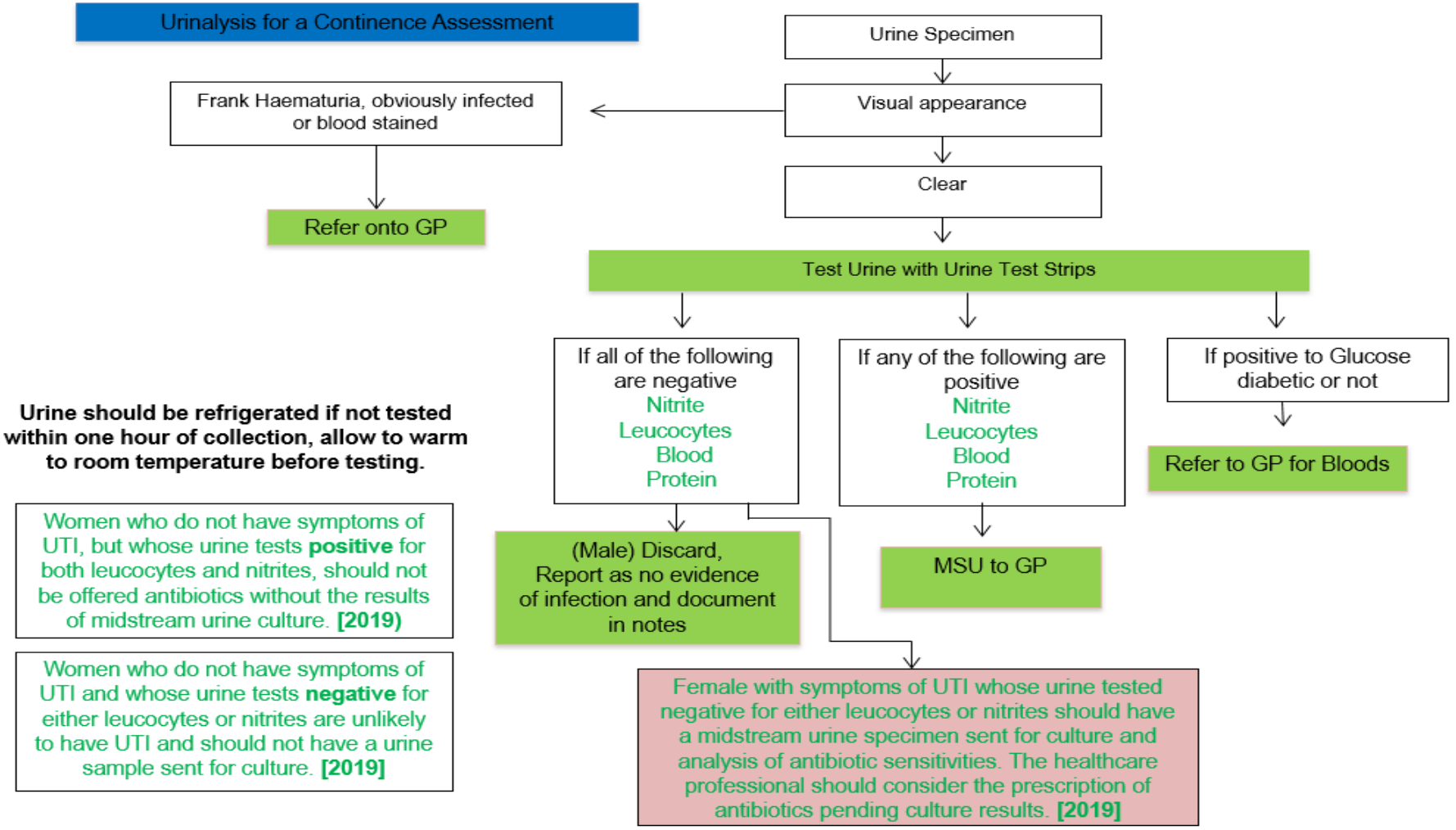
In this column you record any wet episodes by simply ticking the box against the corresponding hour of the day.

Quality of Life – Please choose a score

Appendix 4 Colley Model

https://www.continenceassessment.co.uk/colley_model/

Appendix 5 Urinalysis flow chart

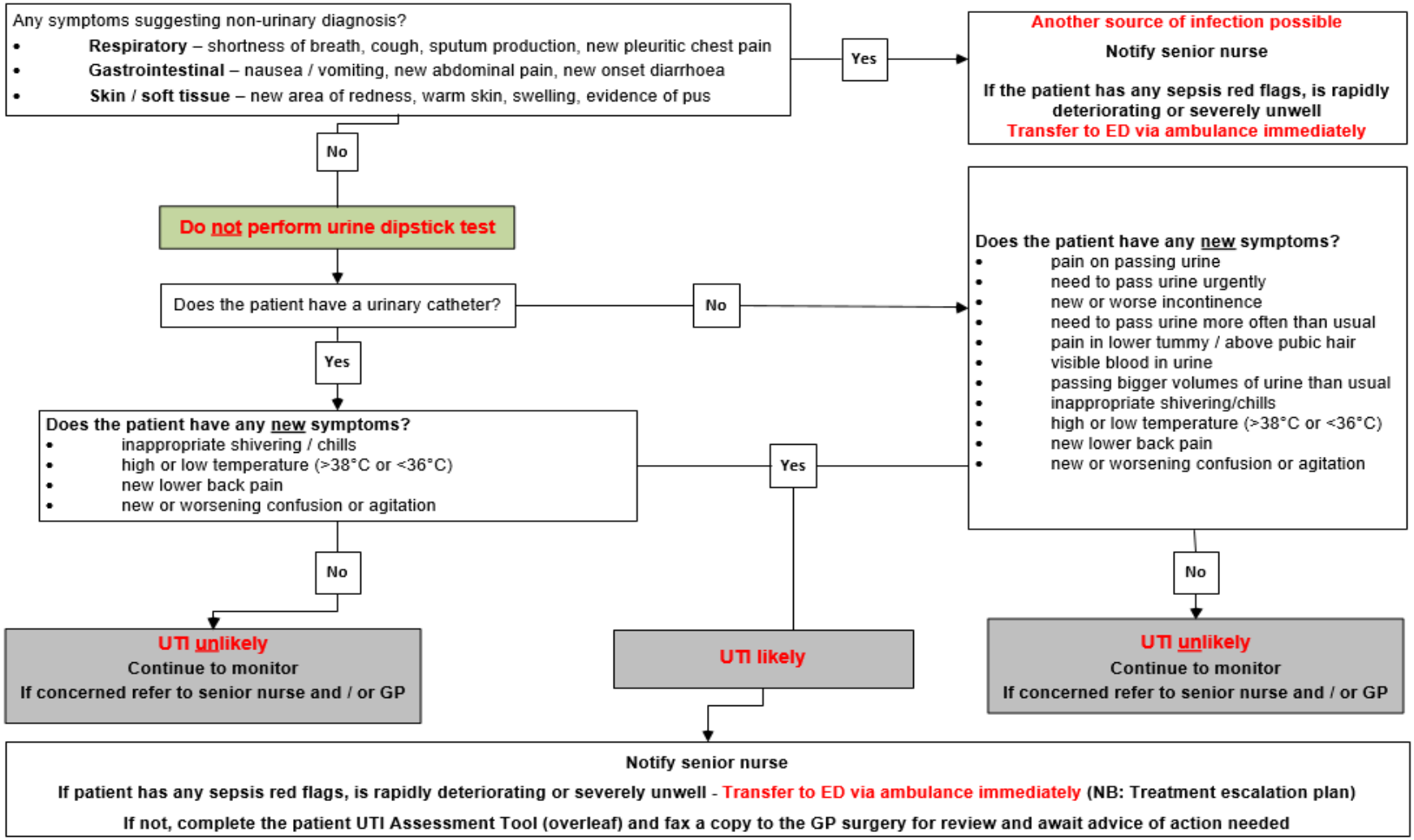


Urinalysis continued

	Negative result	Positive result	Comments
Blood	At risk patients should be tested regularly to ensure intermittent bleeding is detected	Further tests dependent on results from other tests, clinical picture etc. +ve results in the over 40's shouldn't be ignored	Indicates UTI/renal or Urinary Dysfunction. False +ve results are possible due to bleach contaminated containers or stale urine
Glucose	Normal	Follow up with blood glucose analysis so to establish cause	+ve glucose may be due to raised blood glucose levels/reduced renal absorption. May indicate diabetes mellitus/stress/cushing's syndrome/post general anaesthesia/acute pancreatitis
Protein	Insignificant	A +ve result needs confirmation: persistent +ve results indicate renal disease/UTI, hypertension/pre-eclampsia, congestive heart failure.	The nitrite, blood and leucocytes test results should also be noted
Leucocytes	If negative but patient is symptomatic then urine sample will need to be sent off for M,C&S	Indicator of a UTI, to be confirmed with an microscopy, cultures and sensitivity (M,C&S) test.	The nitrite, blood and protein test results should also be noted.
Nitrates	Clinical picture and other results should be considered when –ve result.	Confirm UTI with M,C&S.	Not normally present in urine, but produced when bacteria converts dietary nitrates to nitrates. False –ve results are normally due to insufficient dietary nitrate, lack of incubation time in the bladder or presence of gram positive bacteria

Urinary Tract Infections

Appendix 6 Care Home and Community UTI Assessment Tool



Send MSU (if treatment failure / 2 or more signs of infection)**:**

- put urine in a white topped universal container, fill in the patient details and type of sample carefully to help Pathology process it
- samples should be taken to Pathology / GP practice as soon as possible (it can be refrigerated in the meantime)
- inform the GP that a specimen has been taken

- **patient with catheter** -
  - RGN to take urine sample from needle free port (aseptic non touch technique)
  - consider removing or, if this cannot be done, changing the catheter as soon as possible in people with a catheter-associated UTI if it has been in place for more than 7 days. Do not allow catheter removal or change to delay antibiotic treatment

- **patients without catheter** - try to obtain a urine sample when patient is in the middle of passing urine (rather than at the start)

Care Home & Community UTI Assessment Tool (> 65 years old)

Patient: …… DOB: …… URN: …… Carer: …… Date: …… Contact tel: …… Care Home (if applicable): …… GP: …… Practice: ……	**Older patients (≥ 65 years) with suspected urinary tract infection (UTI)** **Guidance for care home / community healthcare staff:** • complete patient details **and** sections 1-4 • fax copy to GP and put original in patient notes • **DO NOT PERFORM URINE DIPSTICK** (NOT recommended in patients ≥ 65 years) • CLEAR URINE – UTI highly unlikely • **Send MSU** if treatment failure / 2 or more signs of infection (especially dysuria, Temp ≥ 38˚C or **new** incontinence)

1) Catheter in place? (circle) **No / Yes** Reason for catheter ……

2) Signs of any other source of infection, e.g. respiratory, gastrointestinal, skin/soft tissue? No / Yes (If yes circle any NEW symptoms)

Cough Short of breath Sputum production Nausea / Vomiting Diarrhoea Abdominal pain Red / warm / swollen area of skin

3) Can patient communicate symptoms? (circle) **Yes / No**

NEW ONSET symptom	What does this mean?	Tick if present
Dysuria	Pain on passing urine	
Urgency	Need to pass urine urgently / new incontinence	

4) Record for all patients:

Sign / Symptom	Tick if present
Temperature above 38ºC, below 36ºC or shaking chills (rigors) in last 24 hours	……°C
Heart rate more than 90 beats/min	

Frequency	Need to urinate more often than usual			Breathing rate more than 20 breaths/min	
Suprapubic tenderness	Pain in lower tummy / above pubic area			Diabetes	
Haematuria	Visible blood in urine			If no diabetes, blood glucose more than 7.7mmol/L	
Polyuria	Passing bigger volumes of urine than usual			**New** incontinence	
Loin pain	Lower back pain			**New onset or worsening** confusion or agitation	

Any other information: ……

5) GP to action (tick all which apply)	**Tick if required**	**Antibiotic prescribed**
Patient visit needed		
Uncomplicated lower UTI		
Mid Stream Urine (MSU) specimen required – if 2 or more signs of infection		**Any other actions**
Pyelonephritis (dysuria, Temp ≥ 38°C or **new** incontinence) or failed treatment		

Has the Care Home / patient been contacted with clinical decision? (circle) **Yes / No**

Signed: ……... …… Date: ……..

Appendix 7 Treatment/Management Plan

CARE PLAN This document is designed to promote person centred care by detailing what the patient wants, what they can do, how others can help (where agreed) and what the District Nurse service will do based upon the patient's choices and preferences to help achieve their goals and desired outcomes.		
PATIENT NAME:	**DOB:**	**EMIS:**
WHO HAS BEEN INVOLVED IN DEVELOPING THIS CARE PLAN?		
Include names of pt/carers/care providers etc.		

WHAT ARE YOUR NURSING CARE NEEDS?
……. Is having symptoms of urinary incontinence
WHAT ARE YOUR OWN GOALS?
To improve/ manage symptoms of incontinence
WHAT HAVE YOU AGREED THAT YOU OR OTHERS CAN DO TO HELP?
The nurse and I will complete an assessment of my symptoms I/ my carer have completed a 3 day bladder diary
AGREED NURSING CARE PLAN
Intended outcome/aim: 1. The procedure will be explained to me 2. The Nurse will obtain consent from me and will document it 3. Following Assessment we will discuss the cause of my incontinence 4. The nurse has advised me to: Have a fluid intake of …… Go to the toilet at regular intervals……. Avoid caffeinated drinks ☐

Discuss medication with my GP (antispasmodic medicine or hormone replacement) or ask for referral to Urology Dept. ☐

Lose weight ☐

Lay down in the afternoon to reduce overload of fluid ☐

Wear continence pads and has explained how to use them correctly and how to obtain them ☐

Has advised me to not use heavy creams when wearing continence pads ☐

Evidence based intervention based upon patient choice and preferences:

Frequency of review: at each intervention

ADVICE FOR PATIENT, CARER, CARE PROVIDER etc.

What to do if…my symptoms worsen – contact District Nurse Hub

CARE PLAN DEVELOPED BY: Name and designation	**DATE:**

CARE PLAN REVIEWS		
DATE	NAME/DESIGNATION	OTHERS INVOLVED IN REVIEW

Appendix 8 Fluid Intake Matrix

http://www.wales.nhs.uk/Fluid Intake Matrix

Appendix 9 Acute Product Selection Guide

States of Jersey
The States of Jersey Department for Health & Social Services

ACUTE PRODUCT GUIDE

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Products with a 70% Subsidy

Product Name	Illustration	Article No.	Working Absorbency	Inner Packaging
Male Products : Light – Moderate Incontinence (to be worn with snug fitting underwear)				
TENA Men Level 2		CFP213	200mls	20
Shaped Products : Light – Moderate Incontinence (to be worn with snug fitting underwear)				
TENA Comfort Mini Super		CFP336	400mls	28
Belted Products : Moderate – Heavy Incontinence (measure hip size)				
TENA Flex Plus Small 60 - 90cm		CFP1238	700mls	30
TENA Flex Plus Medium 70 - 110cm		CFP1251	750mls	
TENA Flex Plus Large 85 - 125cm		CFP1239	900mls	
TENA Flex Plus Extra Large 105 - 155cm		CFP1240	1100mls	
TENA Flex Super Small 60 - 90cm		CFP1241	800mls	30
TENA Flex Super Medium 70 - 110cm		CFP1242	950mls	
TENA Flex Super Large 85 - 125cm		CFP1250	1150mls	
TENA Flex Super Extra Large 105 - 155cm		CFP1243	1400mls	
All In One Product : Moderate – Heavy Incontinence (measure hip size)				
TENA Slip Super Small 50 - 80cm		CFP1825	750mls	30
TENA Slip Super Medium 70 - 110cm		CFP1629	1000mls	28
TENA Slip Super Large 100 - 150cm		CFP1630	1150mls	
TENA Slip Super Extra Large 120 - 160cm		CFP1862	1200mls	
Shaped Product : Moderate – Heavy Incontinence (to be worn with fixation pants)				
TENA Comfort Normal		CFP1625	450mls	42
TENA Comfort Plus		CFQ908	650mls	46
TENA Comfort Extra		CFQ909	800mls	40
TENA Comfort Super		CFP1626	950mls	36

7th December 2017

TENA

States of Jersey
The States of Jersey Department for Health & Social Services

ACUTE PRODUCT GUIDE

essity

Product Name	Illustration	Article No.	Working Absorbency	Inner Packaging
Pull Ups : Moderate – Heavy Incontinence (measure hip size) **For patients who have been assessed and will not manage a 2 piece product due to dementia or special needs**				
TENA Pants Plus Extra Small 50 – 70cm		CFP1609	700mls	14
TENA Pants Plus Small 65 – 85cm		CFP1610	600mls	14
TENA Pants Plus Medium 80 – 110cm		CFP1613		
TENA Pants Plus Large 100 – 135cm		CFP1614		
TENA Pants Plus Extra Large 120 – 160cm		CFP1653		12

Products not subsidised

Product Name	Illustration	Article No.	Working Absorbency	Inner Packaging
TENA Basic Fixation Pants : to be used with Shaped Products (measure waist size)				
TENA Fix Basic Small 50 – 70cm		CFP1397	-	5
TENA Fix Basic Medium 65 – 90cm		CFP1400	-	5
TENA Fix Basic Large 85 – 110cm		CFP1402	-	5
TENA Fix Basic Extra Large 100 – 150cm		CFP1405	-	5
TENA Fix Basic XXL 140 – 180cm		CFP1407	-	5

7th December 2017

TENA

Appendix 10 Patient Safety Alert

MHRA/Patient Safety Alert

Appendix 11 Equality Impact Screening Tool

Stage 1 - Screening			
Title of Procedural Document: Urinary Incontinence Management and Continence Promotion for Adults			
Date of Assessment	30.11.21	Responsible Department	Adult service Specialist Nurses
Name of person completing assessment	Fiona Le Ber	Job Title	Bladder & Bowel CNS

Does the policy/function affect one group less or more favourably than another on the basis of :		
	Yes/No	**Comments**
• Age	NO	
• Disability Learning disability; physical disability; sensory impairment and/or mental health problems e.g. dementia	NO	
• Ethnic Origin (including hard to reach groups)	NO	
• Gender reassignment	NO	
• Pregnancy or Maternity	NO	
• Race	NO	
• Sex	NO	
• Religion and Belief	NO	
• Sexual Orientation	NO	
If the answer to all of the above questions is NO, the EIA is complete. If YES, a full impact assessment is required: go on to stage 2, page 2		

Stage 2 – Full Impact Assessment			
What is the impact	**Level of Impact**	**Mitigating Actions** (what needs to be done to minimise / remove the impact)	**Responsible Officer**

Monitoring of Actions
The monitoring of actions to mitigate any impact will be undertaken at the appropriate level