Guidelines for the Promotion of Continence and Management of Incontinence in Adults

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# INDEX

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement of Standards for continence</td>
<td>3</td>
</tr>
<tr>
<td>All Wales Continence Care Policy</td>
<td>4</td>
</tr>
<tr>
<td>Prevalence</td>
<td>5</td>
</tr>
<tr>
<td>Aim of Continence Service</td>
<td>5</td>
</tr>
<tr>
<td>Philosophy of Care</td>
<td>5</td>
</tr>
<tr>
<td>Service principles</td>
<td>6</td>
</tr>
<tr>
<td>Key Roles for Continence Promotion Service</td>
<td>6</td>
</tr>
<tr>
<td>Key Role of Health Care Professionals</td>
<td>7</td>
</tr>
<tr>
<td>The Health Care Support Worker Role</td>
<td>7</td>
</tr>
<tr>
<td>Assessment documentation – All Wales Bladder and Bowel Care Pathway</td>
<td>8</td>
</tr>
<tr>
<td>Referral criteria</td>
<td>8</td>
</tr>
<tr>
<td>Level 1 Initial Contact</td>
<td>8</td>
</tr>
<tr>
<td>Level 2 Specialist Continence Assessment</td>
<td>8</td>
</tr>
<tr>
<td>Level 3 Secondary Care Assessment</td>
<td>9</td>
</tr>
<tr>
<td>Role of the Continence Link Nurse</td>
<td>10</td>
</tr>
<tr>
<td>Procedure for referral to the Hospital Continence Advisor</td>
<td>10</td>
</tr>
<tr>
<td>Selection and Use of Disposable Products for the Management of Incontinence</td>
<td>11</td>
</tr>
<tr>
<td>Guidelines to types of incontinence, possible underlying causes and treatment options</td>
<td>13</td>
</tr>
<tr>
<td>Baseline charting</td>
<td>16</td>
</tr>
<tr>
<td>References and related national policies</td>
<td>18</td>
</tr>
</tbody>
</table>
Statement of Standards for Continence

These represent the specific needs and expectations of people with bladder and/or bowel problems in their care.

A person with bladder or bowel problems will expect and have the right to clinical appraisal by an informed health care professional ensuring that they:

- receive a thorough individual assessment of their condition by a doctor or nurse who is knowledgeable in this aspect of care
- are treated with sensitivity and understanding
- become continent if clinically achievable, or be appropriately managed otherwise
- are given information about continence care, including any necessary specialist advice

As health care professionals we will ensure that the person

- is provided with a clear explanation of their diagnosis
- may participate at an appropriate level in full discussion of treatment options, their advantages and disadvantages
- receives regular reviews or changes of treatment when clinically required
- is provided with a personal contact point able to give continuing advice and support
- is provided with appropriate written information

In addition, where continence products are used, health care professionals will:

- provide impartial information on relevant available products and how and where to obtain them
- expect products to have clear written instructions for use in the relevant language

Health care professionals will ensure that

- the professional standards are updated regularly
- the outcome of the service is monitored in line with ABMUHB policy
**All Wales Continence Care Policy**

**Introduction**

The National Service Framework for Older People in Wales (WAG 2006) requires that each health and social care provider has and implements a written policy for continence care. This document highlights the need for an Integrated Continence Service as defined in Good Practice in Continence Services (DOH 2000) for the assessment, diagnosis, specialist treatment and care.

Bladder and bowel dysfunction have many different causes of which incontinence may be a symptom (Norton 2006). For full definitions of lower urinary tract signs and symptoms, refer to the standardization documents at [www.icsoffice.org](http://www.icsoffice.org). It can affect anyone at any age and very often has a devastating effect on the individual’s quality of life. Sufferers find it extremely embarrassing and distressing and it will often lead to social isolation. Incontinence should not be accepted as inevitable, with a thorough assessment, diagnosis, investigation and treatment incontinence can be often cured or improved.

The financial cost of incontinence is enormous. In 2002, the total incontinence related expenditure for the UK was in excess of £420million, with the NHS purchasing £80million worth of absorbent products alone (Euromonitor 1999).

**Scope**

The policy applies to all trained nursing staff and midwives employed by the organisation who are responsible for the care of all adults suffering from bladder/bowel dysfunction and/or incontinence.

**Purpose of the policy**

This policy has been developed:

1. To promote a proactive approach by healthcare staff to the treatment and management of bladder and bowel dysfunction using the All Wales Bladder and Bowel Care Pathways.
2. To inform healthcare professionals of their role and responsibility in continence care.
3. To raise awareness about the key roles of the Continence Promotion service.
4. To guide and enable staff to follow the All Wales Bladder and Bowel Care Pathways.
5. To facilitate appropriate referral to other specialties.
6. To comply with national policies (WAG 2006), guidelines (NICE 2006, 2007) and guidance notes (DOH 2000, WAG 2003, and RCP 2010) amongst others. This list is not exhaustive.
Prevalence

An EPIC study of 1,165 people aged 18 and over revealed that 63.4% suffered from at least one form of lower urinary tract symptoms (LUTS) a subset of continence symptoms. (Irwin et al 2006). Applied to Wales this would mean that more than 1.5m would suffer from LUTS alone. A more conservative estimate shows the prevalence to be 47% of men and 46% of women in the UK aged 40 or over (Coyne et al 2008). Age is a significant risk factor with the prevalence of urinary incontinence increasing to up to 46% with age. (MacLennan et al 2000). However it is difficult to give an accurate figure as it remains under reported and very much a “hidden problem”. It is estimated that fewer than half of adults with moderate or severe urinary incontinence seek help.

Aim of the Continence Service

Abertawe BroMorgannwg University Health Board (ABMUHB) Continence Departments strive to provide a quality service for all patients in the organisation who require assessment, investigation and management of their incontinence problems.

Irrespective of age, gender, physical or mental impairment, patients should have the opportunity for individual, thorough assessment, with the ultimate goal the achievement of continence. Where continence is not possible, then containment should be tailored for individual needs.

Continence management is the responsibility of all health care professionals, and is rapidly achieving a high priority both politically and as a discipline in the NHS. Much effort is now devoted to multi-disciplinary approach involving specialists from a wide range of disciplines. (DOH Good Practice in Continence Services 2000, Dignity in Care 2011).

In order that patients with problems of incontinence may receive the most effective help, this policy is to be used throughout the organisation.

The Continence Services aim to maximise the quality of life for those people with bladder and bowel dysfunction. It will achieve this by providing good quality integrated continence services at outlined in Good Practice in Continence (DOH 2000) and the NSF for Older People in Wales (WAG 2006). The needs of the individuals with incontinence will be met, using research and education to promote continence and manage incontinence in an efficient, effective and comprehensive way.

Philosophy of Care

This policy aims to meet the needs of all individuals receiving bowel and bladder care, respecting their culture, diversity and sexuality. In this respect all care should be patient centred, planned in conjunction with the multi-disciplinary team and extended to the patient’s family and/or significant others. As professionals we are all accountable for the care we provide and it is important that care is based on best clinical practice. Accessing and appraising evidence is becoming a core clinical competency; this offers the potential for enhancing the quality of care patients receive.
All patients who are receiving care within the organisation will have access to the continence service. It is believed that people have the right to be continent where this achievable and the right to the highest standards of available care and management. The service offered will complement and empower existing services and networks, to ensure that the principles of good practice are integrated.

**Service Principles**

- Accessible – on the basis of need
- Efficient – demonstrating value for money and good use of resources
- Effective – delivering desired outcomes, timely and appropriate intervention addressing agreed targets
- Integrated – delivered in a comprehensive framework of health and social care, working across the organisation in close liaison with other agencies
- Participative – supported by user involvement at all levels and working to empower clients to meet their own health need
- Comprehensive – range of service models and interventions appropriate to different age ranges and target groups and supporting client choice
- Appropriate – sensitive to racial, ethnic and cultural aspects, non-judgemental, non-stigmatising
- Developmental – responds to changes in society, culture, environment and economics.
- High quality – demonstrating consumer satisfaction. A high quality service, well motivated staff supported by good information, communication and client education, delivered within a comprehensive quality and audit framework

**Key Roles for Continence Promotion Service**

- To provide advanced second level assessment to patients in the treatment and management of bladder/bowel dysfunction and/or incontinence
- To develop clinical practice guidelines using evidence based practices and pathways of care; ensuring that they are implemented, regularly updated and available to relevant staff
- To monitor quality through clinical audit, taking into account comments and complaints
- To work in partnership with other organisations (e.g. statutory and voluntary organisations)
- To provide educational support and training programmes for the multi-disciplinary teams, and to provide a link/support network of Continence Link Nurses
- To deliver high quality and cost effective services
- To hold current literature/leaflets on the promotion of continence and management of incontinence
- To be involved in national campaigns such as National Continence Awareness Week
- Manage the tendering and delivery of appropriate continence products to patients homes
- Manage the assessment of patients for appropriate continence products in hospital, with provision of advice for all nursing staff on how this may be achieved
- Involvement of patients to work with the service to improve quality of care and service development
For Health Care Professionals

- Healthcare professionals should ensure that they are adequately prepared to undertake clinical continence assessments (NMC 2010)
- Clinical decision making should be enhanced by professionally recognised or evidence based practice. Adopting this means accepting responsibility for the patient, while being able to justify those decisions to peers and patients (NMC 2010)
- Healthcare professionals should be aware of the National Occupational Standards relating to continence care and familiarise themselves with these competencies (www.skillsforhealth.org.uk)
- Link Nurses should receive regular up to date information on continence promotion and management in order that they can help the patient or carer make an informed choice about their management options
- Link Nurses should ensure that patients are assessed to establish whether appropriate continence products need to be supplied
- Each professional team should have the necessary skills to be able to undertake a first level continence assessment
- All qualified nurses with the responsibility for first level continence assessment must have received educational preparation including attendance at local study days
- Link nurse should be aware that continence is not a disease and can be treated, and that the patient is entitled to an assessment by an appropriately trained professional which may not lead to the issue of products as these will only be supplied to patients with intractable incontinence
- Advise patients in the assessment process and by assisting the completion of relevant documentation where appropriate
- Advise patients the importance of attending clinics as appointed or contacting the professional/service to re-arrange/cancel appointments.

The Health Care Support Worker Role

Each Health Care Support Worker should receive appropriate and regular training to enable them to identify the patient’s continence needs. This may include

- Fluid Advice
- The use of frequency/voiding charts
- Skin Care
- Signs and symptoms of urinary tract infection
- Dietary advice
- Correct use of appropriate containment aids
- Reporting any concerns/changes in continence needs
Assessment documentation – All Wales Bladder and Bowel Care Pathway

The All Wales Bladder and Bowel Care Pathway was launched by the Welsh Assembly Government in 2006 and is recognised as the assessment documentation of choice by the NSF for Older People (WAG 2006). These pathways ensure a safe, fair, evidence based approach to continence care and this policy embraces their use and is committed to ensuring their implementation in both primary and secondary care. The All Wales Bladder and Bowel Care Pathway is accessed in its entirety via the HOWIS website or your local continence service.

The All Wales Bladder and Bowel Assessment List/Acute Episode of Care must be used for all inpatients and in the Community the full assessment form must be used. (Appendix 1). This form is also available via the intranet.

Baseline Charting

To enable the optimum investigation, treatment and management of incontinent patients, it is essential that the pattern of the incontinence (or lack or it) is clearly established.

To do this the patient should undergo a minimum 3 day, 24 hour assessment of the patients voiding pattern. (Frequency/Voiding Chart, Appendix 4).

The results should be recorded on the chart provided. This should be given a high priority. Where possible get the patient to complete the chart.

The fluid intake should be recorded each day, and include type of fluid.

At the end of the 3 days determine whether a bladder pattern is apparent.

Referral Criteria

Clients of all ages are eligible for assessment, treatment and management of their bladder/bowel symptoms through assessment levels 1 – 3. Referrals can be taken from any source e.g.

- Self referral
- GP referral
- Hospital/Acute referral
- Social Services
- Nursing home/residential
- Any other source
Level 1 Initial Contact

After identification of the problem referrals can be made for initial assessment to healthcare professionals. Individuals will be assessed by appropriate professionals who have undertaken basic educational instruction in continence issues and the use of the care pathway.

In the hospital setting the All Wales Bladder and Bowel Assessment List/Acute Episode of Care should be completed. (Appendix 1).

In Community documentation is currently being reviewed.

Level 2 Specialised Continence Assessment

Patients can be referred to specialist services if there has been no improvement after initial assessment. However any red flags highlighted on the initial assessment MUST BE referred to the appropriate consultant.

Level 3 Secondary Care Assessment

The Continence Service may need to refer patients to a consultant or specialised service e.g. Urology, Gynaecology, Uro/Gynaecology, Colorectal, Gastroenterology, Care of the Elderly, Neurology, Physiotherapy.

Indwelling catheterisation should only be instigated as management of incontinence as the last resort (RCP 2006). All other containment options should be considered (Catheter Policy 2010).

Quality Assurance, performance monitoring, governance and audit

- Regular monitoring of assessments
- Re-assessment planned 6 monthly, 12 monthly or 24 monthly depending on clinical need
- Client satisfaction audits conducted regularly
- Monthly reports on product usage and costs
- Complaints will be reported and monitored according to local policy
- Regular training and education of healthcare professionals ensures quality of assessments conducted
- Regular updating of clinical skills and competencies of specialist clinical nurses (conferences, study days)

Service Provision

1. Clients will be provided with appropriate incontinence products, provided they have been fully assessed.

2. Where applicable other methods of containment aids will be explored e.g the use of penile sheaths with men.
Role of the Continence Link Nurse

There should be a designated link nurse in each area. All link nurses will have training in the promotion of continence and the management of incontinence.

The functions of the Continence Link Nurse are:

1. To identify their role with the nursing, medical and paramedical staff within their area of work. To act as a resource in their area. This will include basic advice on treatment options such as pelvic floor exercises, bladder drill, advice on fluid intake, toilet regimes, bowel management and catheter care. To be aware of appropriate and correct use of aids. (All Wales Bladder and Bowel Care Pathway 2006).

   At all times remembering that if there is any doubt at all about diagnosis contact the continence advisor for advice.

2. To disseminate information about any changes in the promotion of continence and management of incontinence to all healthcare professionals.

3. To meet regularly with Continence Advisors for updating, education, discussion of cases and problems, exchange of information and promotion of ideas.

4. To invite and evaluate comments from colleagues on products used and participate in product evaluation.

Procedure for referral to the Clinical Nurse Specialist/Continence Advisor

1. Initial assessment should be made using the Acute Episode of Care Form (Appendix 1) by the healthcare professional with advice as required on management from the Link Nurse.

2. In the event of failure of initial management or treatment options the patient should be referred to the Clinical Nurse Specialist/Continence Advisor.

3. If the patient has a complex continence problem, or the patient needs specialist investigation then the patient needs to be referred to the Clinical Nurse Specialist/Continence Advisor.

4. If the patient needs incontinence containment products on discharge from hospital an ABMUHB Continence Assessment Selection Guide for pads (See Appendix 2) should be completed, as early on in the discharge process as possible.

   This form, together with the All Wales Bladder and Bowel List/Acute Episode of Care form, should be forwarded/faxed to the appropriate Clinical Nurse Specialist/Continence Advisor.
It can take up to 10 working days to process these requests in the community. Patients who are discharged from hospital must be given at least 7 days supply of products. Patients should be made aware that they may have to purchase their own products for a short period.

**Selection and use of disposable products for the management of incontinence**

**Pads, pants and bedding protection**

Containment aids are requisitioned from Bridgend Stores and stored in various locations across the organisation.

Containment aids are issued to the wards by appropriate requisition. It is controlled and monitored by the Continence Advisor, and there is liaison with Link Nurses at ward level.

If the patient is in receipt of products in the community they should be encouraged to bring their supply into hospital to maintain continuity.

Requests for products should be proceeded by:

- assessment to determine the type and degree of incontinence
- initiation of the treatment plan
- assessment of the type of pad needed

When selecting and using containment aids the nurse should at all times:

- Ensure patient comfort and dignity
- Assess the practical efficiency of the product
- Ensure the best use of resources

Instructions on the use and disposal of products is the responsibility of the health care professional issuing the products. Fitting guides for products are available from the contracted company. Ongoing training is provided on a regular basis by the contracted company.

The degree of absorbency of the pads depends upon the composition and not the size of the pad. Normally, the manufacturers recommended "working absorbency" indicates the capacity of the pad before leakage will occur.

Regular evaluation of the products used by the patient is essential as personal needs change and also to ensure that the product is being used correctly.

In order to facilitate this, the assessment will match the patient’s needs with the properties of the product.
Selection

A. The following general points should be considered:

- the personal needs of the individual, their comfort and dignity
- the quantity of urine and/or faecal loss
- disposal of soiled pads
- availability of these products either by the organisation or private purchase when the patient is discharged

B. Key points in the selection are:

- Is the patient MALE or FEMALE
- Is the patient AMBULANT or BEDFAST
- Degree of MOBILITY
- Availability and retention of SPECIAL SENSES
- Degree of MANUAL DEXTERITY
- INTELLECTUAL CAPACITY
- Degree of PHYSICAL DISABILITY (including thigh abduction)
- WEIGHT of the patient

C. What degree of incontinence does the patient have?

- Urine - LEAK, DRIBBLE, GUSH
- Faecal - LIQUID, SOLID
- DAYTIME or NIGHT TIME Incontinence

Instructions will be given to the patient on:

1. Correct fitting of product
2. Where supplies can be obtained
3. How to launder re-useable garments
4. How to dispose of pads within the community. In secondary care local policy will be adhered to
5. Patients in the community who are deemed to require special collection due to infection will be advised accordingly.

With all products, correct fitting and management should be demonstrated and simple, clear, written instructions issued to the patient/carer. Details should be given regarding sources of further supplies and disposal of disposable products. Appropriate barrier creams should be used sparingly and should not be oil based.

Disposable bed sheets are for use only with procedures such as enemata, and not as incontinence bed protection. They are not recommended for use at all where the patient’s skin is broken.
When requesting a product, the healthcare professional will quote:

- details of the incontinence assessment and treatment plan
- product description and one packet of pads per patient

A sample of each continence product available and details of its approximate absorbency and cost, will be kept by the Continence Advisor and Link Nurses. Product details are also available on the ABMUH Preservation form (Appendix 2). Limited samples of specialised products will be available from the Link Nurses via the Continence Advisor with details of ordering and costs.

**Incontinence products will not be substitutes for toileting.**

A more comprehensive range of containment aids is available within the community setting for long term management of intractable incontinence. These will be issued according to clinical need – on average 3 – 4 products within a 24 hour period.

**Catheters and urinary drainage systems**

For detailed advice regarding catheters and their management please refer to the ABMU Health Board Catheter Policy (2010).

**Guidelines to types of incontinence, possible underlying causes and treatment options**

**Stress Incontinence**

This is leakage of urine associated with sudden physical stress which in turn will increase abdominal pressure on the bladder. This can be caused by coughing, laughing, exercise, or any sudden movement; normally the patient will be dry at night.

It can be caused by underlying urethral sphincter incompetence or pelvic floor weakness.

Treatments may include pelvic floor exercises, electrical stimulation or in the last instance surgical intervention.

**Urge incontinence/Overactive bladder**

This is involuntary leakage of urine which is caused by uninhibited contraction of the bladder (detrusor) muscle. Incontinence will often follow strong desire to void. Patients are often wet at night. There is often associated urinary urgency and frequency (>8/24hrs) or "latchkey" incontinence.

It can be caused by idiopathic detrusor overactivity, which can be secondary to neurological disease. It can also be caused by bladder calculus and cystitis, urinary tract infection, or inappropriate fluid intake and type of fluid.
Treatments may include advice on fluid intake, bladder retraining programme and antimuscarinic drugs.

**Stress induced urgency**

The bladder may be sensitive to stimuli such as a cough which may set off a bladder muscle contraction, which in turn causes incontinence immediately after coughing.

**Outflow obstruction**

This is obstruction of the flow of urine during voiding. This can be characterised by continual dribbling, a weak urinary stream, hesitancy, incomplete emptying, straining to void or post micturition dribbling. Most commonly associated with prostatic hypertrophy but can also be caused by an urethral stricture. Occasionally a neurological lesion can prevent co-ordinated relaxation of the urethra during voiding, even when there is no physical obstruction to the flow. This is termed detrusor sphincter dyssynergia.

The patient may often be wet at night.

Treatment options may include clearing any faecal impaction, clean intermittent self catheterisation, if the residual is greater than 150mls. Otherwise refer for urological opinion.

**Atonic bladder**

This is a bladder which does not produce a proper voiding contraction. Residual urines will build up and emptying will only occur with abdominal effort or ISC. Sensation is frequently diminished, the residual urine volume will increase and often overflow incontinence will occur. Can be caused by peripheral nerve damage in diabetes or damage to the lower spinal cord, or feedback loop to the brain stem.

Management may include clean intermittent self catheterisation.

**Incontinence due to cognitive impairment**

This can be caused by diseases of the central nervous system (e.g. Dementia, CVA).

Treatment may include a bladder toileting programme.

**Incontinence due to physical impairment**

In this instance the incontinence can be caused by impaired dexterity or mobility, which may or may not be due to an underlying condition.

Treatment may include a bladder retraining programme and advice from the multi-disciplinary team including physiotherapists and occupational therapists.
Nocturnal enuresis

Primary nocturnal enuresis (bedwetting) can affect 1-2% of adults. (Yeung et al 2004). Enuresis can also be caused by detrusor overactivity, prostatism or immobility.

Treatment may include alarm therapy, Desmopressin and fluid advice.

Reflex incontinence

Some patients who have spinal injuries may experience a lack of awareness of bladder filling or the desire to void. Filling and voiding will take place automatically and without warning.

Continuous incontinence

Occurs when a fistula is present between the bladder/urethra and vagina. Faeces in the vagina will indicate a recto or ano vaginal fistula.

Faecal incontinence

This can be caused by anal sphincter weakness or damage, intestinal hurry, impaction with overflow, or neurological damage or disease.

Symptoms can include urgency and urge incontinence of faeces, loose stool, passive soiling. In the case of impaction with overflow there can be passive loss of "spurious diarrhoea" or solid stool.

The use of the Bristol Stool Chart (Appendix 3) is appropriate. Any rectal bleeding or change in bowel habit should be investigated.

Treatment may include sphincter exercise if there is sphincter weakness, encouraging a firm stool with medication and diet, giving constipating agents in the case of intestinal hurry.

For impaction with overflow, the first thing is to "disimpact" then keep the rectum empty.

With patients with neurological disease attempts must be made to regulate bowel habit, and/or control evacuation with laxatives.

It is important to note that patients can have a combination of different types of incontinence.

The questions on the assessment form about mobility, dexterity etc are all very important as problems with any of these may actually cause incontinence or may be contributory factors.
Referrals to the Clinical Nurse Specialist/Continence Advisor should be accompanied by

- All Wales Bladder and Bowel Check List/Acute Episode of Care form
- Frequency/Voiding Chart
- ABMU Health Board Selection Form for products

Relevant medical history should be included.
References and Related National Policies


All Wales Bladder and Bowel Care Pathway (2006) Welsh Assembly Government, Cardiff

All Wales Continence Policy 2008


Department of Health (1998) A First Class Service: Quality in the new NHS

Department of Health (2001) Essence of Care: patient focused


17


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


Appendix 1
<p>| <strong>ALL WALES BLADDER AND BOWEL ASSESSMENT LIST</strong> |
| <strong>ACUTE EPISODE OF CARE</strong> |
| <strong>NAME:</strong> | <strong>HOSPITAL NUMBER:</strong> |
| <strong>DATE OF BIRTH:</strong> | <strong>TO COMPLETE FOR PATIENTS PRESENTING WITH BLADDER/BOWEL DYSFUNCTION</strong> | <strong>Y/N</strong> | <strong>ACTION</strong> | <strong>OUTCOME</strong> |
| <strong>Does the patient have haematuria, pain, recurrent UTI</strong> | | | <strong>Refer to Medical Staff for urology referral</strong> | |
| <strong>Did this patient have a bladder problem prior to admission?</strong> | | | | |
| <strong>If yes, has it been investigated previously?</strong> | | | <strong>Confirm management with Community Services</strong> | |
| <strong>Do they have frequency/urgency/nocturia/hesitancy, dysuria or any other urinary symptom?</strong> (delete as appropriate) | | | Frequency/Volume Chart | |
| | | | Urinalysis | |
| | | | Check for constipation | |
| | | | Medication review by medical staff | |
| <strong>Does the patient have a feeling of incomplete emptying or do you suspect they are not emptying their bladder properly?</strong> | | | Check residual urine (use bladder scanner or intermittent catheterisation) | If &lt;100mls no action |
| | | | | If &gt;100mls consider referral to appropriate specialist service |
| <strong>Do they have urgent leakage of urine?</strong> | | | Instigate a regular Toileting programme | |
| | | | Fluid advice | |
| | | | Information leaflets | |
| | | | If no improvement refer to Continence Service | |
| <strong>Do they leak urine on coughing/sneezing?</strong> | | | Refer to Link Nurse | |</p>
<table>
<thead>
<tr>
<th><strong>Do they have any rectal bleeding, change in bowel habit, mucus in stool, pain or associated weight loss?</strong></th>
<th><strong>Refer to Medical Staff for consideration of specialist referral</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have a regular bowel action of 1-3 days?</td>
<td></td>
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</table>
| Do they have any faecal incontinence/soiling? | Use bowel chart  
Regular toileting |
| Do they have to strain to evacuate their bowels? | Use bowel chart  
Check consistency of stool (Bristol Stool Chart) |
| Does the patient have functional problems eg limited mobility, dexterity or cognitive problems? | Regular assisted toileting  
Refer to MDT |
| **Does the patient require incontinence aids?**  
If yes to pads please complete **SUPPORT PRODUCT SELECTION TOOL** | Please specify eg sheath, commode, urinal, other continence device |
| Are pads required on discharge? | Liaise with appropriate professional and Inform Continence Service in accordance with local policy  
*Ensure a copy of the assessment form is forwarded to the Community Continence Service* |
| Does the patient require more specialist advice? | Refer to the Continence Service |
| **Medical History** | **Drug History** |
## The Bristol Stool Form Scale

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

ABERTawe BRO MORGANNWG UNIVERSITY HEALTH BOARD
CONTINENCE ASSESSMENT FORM

<table>
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<td><em>Please complete all of this section</em> Admission</td>
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<td>Recovered</td>
<td>Section Changed</td>
</tr>
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<td></td>
<td></td>
<td>Moved out of Area</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Died</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospital / NH</td>
<td>3</td>
</tr>
</tbody>
</table>

*PLEASE INDICATE*

NO CHANGE

<table>
<thead>
<tr>
<th>PATIENT DETAILS:</th>
<th>1</th>
<th>G.P. NAME &amp; PRACTICE:</th>
<th>2</th>
</tr>
</thead>
</table>

SURNAME

OTHER NAMES

SEX: M / F D.O.B.

TYPE OF INCONTINENCE
URINE □ FAECAL □ DOUBLE □

NURSING / RESIDENTIAL HOME

LEARNING DISABILITIES □

ADDRESS

DATE OF REQUEST

BASE

POST CODE

ASSESSING NURSE

TEL NO: (home)

TEL NO: (other)

PLEASE ENTER QUANTITY IN BOXES BELOW

<table>
<thead>
<tr>
<th>PRODUCT TYPE</th>
<th>Euron Let (Rectangular)</th>
<th>Euron Flex (Shaped)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PAD</th>
<th>Insert 1</th>
<th>Mini</th>
<th>Maxi</th>
<th>Large</th>
<th>Extra</th>
<th>Super</th>
<th>Extra Plus</th>
<th>Super Plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICTURE</td>
<td>Light</td>
<td>Light</td>
<td>Light</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Heavy</td>
<td>Heavy</td>
<td>Severe</td>
</tr>
<tr>
<td>Total Absorbency</td>
<td>330 mls</td>
<td>650 mls</td>
<td>620 mls</td>
<td>890 mls</td>
<td>1500 mls</td>
<td>1800 mls</td>
<td>2400 mls</td>
<td>2700 mls</td>
</tr>
<tr>
<td>Cost Per Pad</td>
<td>4p</td>
<td>3p</td>
<td>7p</td>
<td>8p</td>
<td>14p</td>
<td>15p</td>
<td>16p</td>
<td>18p</td>
</tr>
<tr>
<td>NO PER 24 HRS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Code</td>
<td>1711020</td>
<td>58950520</td>
<td>1722280</td>
<td>17231280</td>
<td>11502280</td>
<td>11504280</td>
<td>11506280</td>
<td>11508280</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PRODUCT TYPE</th>
<th>Euron Form (All-In-One)</th>
<th>Euron (All-In-One)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PICTURE</td>
<td>Moderate</td>
<td>Severe</td>
</tr>
<tr>
<td>Waist/Hip Size/kg</td>
<td>40 - 70cm</td>
<td>50 - 90cm</td>
</tr>
<tr>
<td>NO PER 24 HRS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Code</td>
<td>14506140</td>
<td>14518140</td>
</tr>
<tr>
<td>Code: 16262280</td>
<td>Euron Soft Extra Underpad - 60 x 60 cm</td>
<td>Case Qty: 4 x 28</td>
</tr>
<tr>
<td>Code: 16264280</td>
<td>Euron Soft Super Underpad - 60 x 60 cm</td>
<td>Case Qty: 4 x 28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHICH SIZE: Stretch Pants</th>
<th>Small</th>
<th>Medium</th>
<th>Large</th>
<th>X Large</th>
<th>XX Large</th>
<th>Packs of 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>P&amp;S Healthcare Reusables:</td>
<td>Unisex Briefs</td>
<td>Ladies Full Brief</td>
<td>Y Front</td>
<td>Community Bed Pad (Pants 3 pairs per year)</td>
<td>(Bedpad - 2 per year)</td>
<td></td>
</tr>
</tbody>
</table>
VOIDING CHART

Please complete this confidential form as honestly and accurately as possible and bring it with you when you come to the Clinic.

Note the time you pass water. Measure the amount passed using any measuring jug. Write down the time and the amount in cc’s or mls.

If you wet yourself write down the time and write the letter W in the amount column.

Please keep the chart for any three days.

Please also record the fluids that you drink. Try to indicate the amount AND the type of fluid eg: 3 glasses of water / 4 cups of tea.

An example of how your chart might look is given below.

<table>
<thead>
<tr>
<th>Name: MARGE SIMPSON</th>
<th>Hospital No. 012745</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DATE</strong></td>
<td><strong>DAY 1</strong></td>
</tr>
<tr>
<td><strong>TIME</strong></td>
<td>EXCRETA</td>
</tr>
<tr>
<td><strong>DAY</strong></td>
<td></td>
</tr>
<tr>
<td>7:00 a.m.</td>
<td>110 cc</td>
</tr>
<tr>
<td>10:30 a.m.</td>
<td>2 a.m.</td>
</tr>
<tr>
<td>9:00 a.m.</td>
<td>1 a.m.</td>
</tr>
<tr>
<td>6:00 p.m.</td>
<td></td>
</tr>
<tr>
<td>11:00 p.m.</td>
<td></td>
</tr>
<tr>
<td><strong>NIGHT</strong></td>
<td></td>
</tr>
<tr>
<td>2:00</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
</tr>
<tr>
<td>800 cc</td>
<td></td>
</tr>
</tbody>
</table>

H:\Information Sheets\TRUST Voiding chart.doc