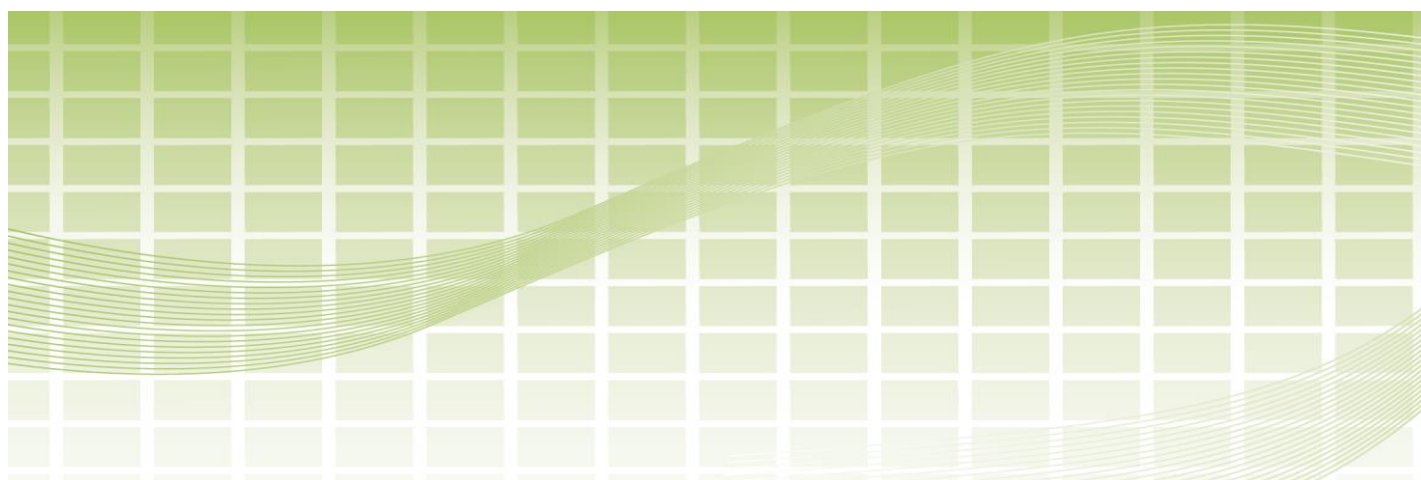


Guidance for the provision of containment products for adult incontinence

A consensus document
2017



**Association for
Continence Advice**

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Document Purpose	Guidance/Policy
Document name	Guidance for the provision of containment products for adult incontinence: A consensus document
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Target Audience	CCG Clinical Leads, Foundation Trust CE's, Directors of Nursing, Local Authority CE's, NHS Trust Boards, Allied Health Professionals, GP's, Consultants, Directors of Nursing; NHS Trust CE's, Continence Service Leads, Care Homes and members of the public
Additional Circulation List	Continence Services across England (although other countries may find the document useful)
Description	Consensus document regarding the provision of continence containment products for adults, to ensure all adults who suffer with urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service
Cross reference	Excellence in Continence Care (NHS England 2015) Minimum Standards for Continence Care (2014) Guidance for the provision of continence containment products to children and young people: a consensus document (2016)
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Purpose

Best practice is where clinical assessment and personalised care planning is a fundamental activity prior to any provision of product, from the age of 18 years old. Transition for the child/young person to adult continence care should be underpinned by the both the Child and Young Person consensus document (Bladder and Bowel UK 2016) and this document. The document was produced through a consensus approach predominantly via membership of the Association for Continence Advice. Any conflicts of interests were managed and agreed reached via discussion.

Within England, there is no statutory requirement for the provision of containment products for incontinence, resulting in each health care trust, commissioning group, health board or health and social care board developing their own policy and guidelines. Consequently, the variation and discrepancy in access to provision has resulted in cost pressures and disproportionate distractions from best clinical practice. Clinical assessment is a critical component in the diagnosis of the cause(s) of incontinence and should be following by treatment opportunity before considering containment products.

Accountability

The clinician who clinically assesses to provide a continence product is accountable for that decision and needs to ensure that the product is fit for purpose. Furthermore, that the product is safe for the patient to use at the time of clinical assessment. Specific attention must be paid to safety when prescribing products that may carry a potential for increased falls risk, for example disposable pants or disposable bed sheets. Where risk exists, it is recommended to seek advice from the multi-disciplinary team or continence service. The patient or carer should be advised on how to apply/use the product and has been given sufficient information and training in the safe use of the product.

The clinician must also ensure the assessment for a suitable continence product takes account of the environment(s), within which the products issued, will be used. For example, 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 product 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.

Background

People should have the right to receive the right treatment at the right time and live the best achievable quality of life possible (NHSE 2015). The Francis Report (DH 2010) highlighted poor patient experience in bladder and bowel continence care, which gave the 'impression of continuous neglect'. Of 33 cases heard during the enquiry, there were significant concerns for 22 of the cases, most notably:

- Poor response to patients requesting assistance
- Patients being left in soiled sheets
- Patients being left on commodes
- Uncaring and unsympathetic attitude of staff

Dignity and quality care is at the heart of continence care provision. Skilled and trained staff across health and social care communities are fundamental to delivering this (Rantell et al 2016).

Current issues

Bladder and bowel problems are common and in most cases treatable, but they are poorly understood and under-prioritised within health and care provision in England (RCP 2010; Orrell et al 2013). Estimates of the burden of incontinence in England reaches up to 12.5 million people (ONS 2015).

Although the risk of incontinence increases with age and is one of the main reasons for care home admission, symptoms affect every section of the population, including children, people with a learning disability or other chronic condition as well as otherwise healthy adults. Incontinence is a symptom, not a disease or diagnosis and has many possible causes as well as being only one of a range of other bladder or bowel symptoms. Urinary and faecal incontinence has been defined as ‘the complaint of any involuntary leakage of urine or faeces’ (Abrams et al 2002). Treatments are varied and it is therefore important to diagnose the cause(s) accurately. There is an increasing body of knowledge about the clinically effective treatments for most types of faecal and urinary incontinence, particularly through clinical guidance and quality standards (NICE 2007, 2008, 2010, 2012 and 2013; SIGN 2006).

The impact of moderate symptoms on quality of life has been found to be similar to that of diabetes or high blood pressure, affecting a person’s independence, their productivity, sleep and mental wellbeing. The lack of timely access to high quality assessment, care, treatment and support in England has been well-documented over time (APPG 2011; NHSE 2015; BGS 2016). Poor continence care is not only distressing and degrading for individuals, it also contributes to unnecessary costs to the NHS through avoidable complications such as infections, pressures ulcers and falls, which can increase the amount of time spent in high cost hospital settings (Expert Group on LUTS 2014).

There is no question that demand for continence services is, and will continue to be, compounded by the changing demographics of the population of England, the increasing pressure on related statutory services, improved techniques in neonatal diagnosis and early year’s intervention in health care, an ageing population and better management of chronic conditions. Effective community-based continence services can save valuable NHS resources whilst restoring dignity to people and improving quality of life (NHSE 2015).

Previous national guidance advised that commissioners should move towards direct provision of products for nursing home residents and that reimbursement arrangements only continue on an interim basis (NHS 2009). Unfortunately, this hasn't been implemented for many homes across England.

Continence care requires a higher priority than it currently receives, as improving provision through better integration can improve outcomes and better quality of life; and increased independence through finding solutions appropriate to individual needs. For example:

Use of containment products and intervention

- Using alternative treatments, there will be less reliance on pads and products as currently the number of patients requiring NHS products is increasing year on year (Wagg et al 2008).
- Providing and procuring through a joint standardised process across England will result in a more cost – effective approach to purchasing continence products
- Treating overactive bladder syndrome in women produces Quality Adjusted Life Years (QALY's) gains and can reduce reliance upon containment products (Phillips et al 2015).
- Low cost community interventions can cut pad usage by 50% (Imamura M et al 2010) such a focusing on lifestyle improvement measures.
- Cost of pelvic floor interventions and bladder retraining is offset by a reduction in product usage (Demaagd and Davenport 2012; Borrie 2002)
- The multiprofessional approach to care should involve Occupational Therapy, Physiotherapy and other disciplines (such as Learning Disability or Mental Health Nurses) as required, as this can support individualised toileting programmes, support patients with functional incontinence and help to reduce reliance on and costs of high absorbency containment products (Spencer et al 2017).

Infections

- Reducing the use of indwelling catheters can help to reduce catheter associated urinary tract infections (CAUTI'S) in combination with evaluation, education and training (NICE 2012; Slyne et al 2012).
- Pressure ulcers and incontinence associated dermatitis is a national priority and identifying, assessing and treating continence issues can significantly reduce skin problems <http://nhs.stopthepressure.co.uk/>
- Urinary tract infections are prevalent especially in older women untreated UTI's in men can lead to urinary retention <https://www.niddk.nih.gov/health-information/urologic-diseases/bladder-infection-uti-in-adults>
- Optimum symptom management can help to reduce infections (Shaw and Wagg 2017).

General Population and Care Home admission

- Incontinence is a significant factor for admission to hospitals and care homes (Leung and Schnelle 2008)
- 50% of care home (with nursing) residents have faecal incontinence which is a treatable condition (Leung and Schnelle 2008)
- Three quarters (73%) of hospital admissions for constipation are emergency admissions (HES 2012)

However, not all costs are financial. There is a large body of evidence about the effect of continence problems not just on the system, but on people's lives. There can be considerable psychological impact, affecting confidence, achievement and integration into society, personal relationships, body image and intimacy.

Best practice statements for the provision of products

This guidance assumes that clinical assessment and first-line treatment has taken place, and the patient has a clinical need for product provision.

All care settings

1. Men and women should be treated equally in relation to absorbencies and product range available.
2. All adults with an identified continence problem must be offered a comprehensive bladder and/or bowel clinical assessment of their continence condition, with appropriate identified interventions undertaken and reviewed. A positive response to the trigger question, "*Does your bladder or bowel ever/sometimes cause you problems?*" must lead to a comprehensive bladder and or bowel continence assessment.
3. For adults 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.
4. The registered healthcare professional remains accountable for the clinical assessment of continence and instigation of first line treatment. The responsibility of undertaking a continence assessment can only be delegated to a non-registered healthcare professional who can demonstrate the necessary theoretical knowledge, skills and expertise, from Band 4 (Foundation Degree level) upwards. Clear lines of accountability and supervision by the registered healthcare professional who delegated the task must be in place.
5. Reassessment of product provision should be undertaken annually as a minimum. Patients should co-operate with reassessment and should they choose not to make themselves available or decline reassessment, then product provision via the NHS will be suspended or cease.

6. Individuals will self-fund products until a clinical assessment has taken place. However, clinical assessment timescale (within referral to treatment time targets) should be in agreement with the local Clinical Commissioning Group.
7. Containment products 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 products will not be offered as an alternative.
8. Alternative collection devices should be considered for example, prescription urinals, urinary sheaths and body worn urinals, bags and adaptive underwear (e.g. specialist briefs with adapted collection systems).
9. The number of products issued per 24 hours would normally not exceed 4, but provision should meet assessed clinical need. As part of the continence assessment process a validated scoring system should be in place to objectively measure "clinical need" in continence care.
10. Lowest absorbency disposable products provided by NHS should be no lower than 400mls working absorbency. Washable continence containment products should be available via the NHS for light (low volume) urinary incontinence. If clinically appropriate, items are also available on prescription such as urinary sheaths, body worn appliances or anal plugs for light urinary and faecal incontinence. Small lower absorbency disposable pads are available from a variety of sources for self-purchase.
11. Faecal ONLY product: Where an individual presents with faecal loss only, a simple, rectangular pad should be recommended (super absorbent powder included in body of pad is not necessary).
12. The use of a two-piece system should be promoted where possible. For individuals where this isn't appropriate, the use of alternative styles may be necessary. All-in-one products should NOT be issued for patients who are able or capable of being toileted/using a toilet; and should not be supplied to inpatients/care home patients where 24 hour care is available, unless toileting is clinically contra-indicated, and the product has been authorised by the continence nurse specialist or the budget holder.
13. Individuals in receipt of NHS products should take enough supply when going on holiday or anticipated periods of time away from home.
14. Exceptions (e.g. not registered with a GP practice or clinical need beyond local guidance/policy) should be subject to a robust system that escalates cases to the Clinical Commissioning Groups (CCG's) for consideration of additional funding on an individual case basis. Funding should follow the patient and any extra product cost accounted for.

15. Authorisation for bariatric products, maximum absorbency products e.g. over 1100mls, belted products and disposable pants may be required from the continence nurse specialist or the budget holder.
16. Transition of children/young people into adult services should be cognisant of the need for continuation of continence care.
17. Transfers between service areas – if products or quantity differs and the patient has not had an updated clinical assessment within the last 6 months (that can be made available to the specialist continence service in the area the patient has moved to), the patient will have to undergo a new clinical assessment; adhering to local provision until such time as an “exception/ outside of policy/above policy” case is made to the CCG for consideration.
18. Funding for product provision should be kept separate from continence clinical services. As product costs and quality data (for example product quality assurance, IT systems support and information governance, Registered Nurse Advisors, educational training and support, patient information, delivery and customer services) are commercially sensitive and should be available on a confidential need to know basis to CCG's and GP's when assessing or planning services to meet the overall health needs of their population.
19. Consideration of NHS procurement on a larger geographical footprint would reduce postcode lottery/variation when moving across regions.
20. Audit information from Home Delivery data collection and reporting systems should facilitate comparisons and benchmarking at national level.

Acute hospital inpatient care, Community Hospitals and Community Settings

21. Where an elective surgical procedure is anticipated; and it carries the potential risk of incontinence post operatively, the key healthcare professional should consult with or refer the individual to the specialist continence services prior to the operation (e.g. prostate surgery).
22. If incontinence is anticipated whilst as a hospital in-patient, individuals will be encouraged to bring products into hospital ready for discharge. Hospitals are not responsible for providing products for discharge.
23. During their hospital stay, all individuals with incontinence symptoms must have a baseline continence assessment completed and any first line treatment initiated. Where a continence assessment has previously been performed, this information should be transferrable between settings and reviewed accordingly. In unresolved incontinence or in more complex cases, referral should be made to inpatient continence services if available. If incontinence symptoms have not resolved prior to discharge home, the hospital team must refer the patient for further clinical assessment on their return home. The hospital must have a robust discharge process in place to ensure individuals are assessed by an accountable healthcare professional in accordance with section 1 point 4. An

interim product supply should continue until reassessed in the community setting, to ensure that the patient is not placed at immediate risk. Individuals may need to self-fund supplementary products until a community continence assessment has taken place, which can be as long as 8 to 12 weeks.

24. Inpatient services should have a standard product formulary, which is adhered to and to avoid undue confusion for patients and carers, aligns with the local community formulary. If clinical assessment identifies a need outside the formulary advice must be sought from the specialist continence service.
25. Products will not be supplied before the individual person has undergone a comprehensive clinical assessment. Exceptions to this are for individuals with limited life expectancy (within 6 months) or for emergency inpatient hospital admissions during the period of an acute illness, where a comprehensive assessment is not possible, however a full comprehensive assessment must be undertaken once the acute episode has stabilised. Assessment must be undertaken prior to discharge if incontinence is unresolved. Discharge from hospital must not be delayed for the inpatient with identified continence needs; a continence assessment must be made a priority issue prior to discharge.

Care Homes (Nursing & Residential)

26. All care home residents, both nursing and residential (regardless of funding arrangements) should receive assessment, treatment and products via the same NHS system to ensure quality and equity. Financial reimbursements only are not recommended and where this exists, the move to a provision system should be raised and managed between the CCG and the continence service providers.
27. Care homes where residents are in receipt of NHS products must co-operate with periodic audit by the NHS product provider to ensure efficient use of NHS funded products and resident's clinical needs are met. Furthermore, to identify any staff training that may be required to support product use.
28. When a CCG provides funding for a person who requires residential care outside of their boundary that CCG will be responsible for the cost of any incontinence products that maybe required by that person.

Future intentions

The following recommendations are aspirations, which aim to be woven into national policy and guidance decisions as and when the opportunity occurs:

- A national standardised clinical assessment electronic template and scoring system to be consistently available across the UK.

- Innovative models of continence care delivery to ensure patients do not continue to fall between the gaps of care sectors. Thus reducing the risk of falls, readmission, tissue viability issues and social-psycho distress.
- National non-branded patient information leaflet regarding NHS continence products provision, with space so details of local continence services can be added.
- Public support networks - increased co-operation between NHS and voluntary sector to offer wider public support networks via independent charitable organisations such as Bladder and Bowel UK; and Age UK, etc.
- Options for containment product to be incorporated within the personal budget system.
- Improved Care Quality Commission inspection of the quality of clinical assessment and treatments within Care Homes.

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