National Community Operations

Guideline for the assessment, promotion and management of continence in adults by registered nurses 2019

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Table of Contents

Guideline for the assessment, promotion and management of continence in adults by registered nurses.

Outline of steps for carrying out a baseline continence assessment (level 1)

This reference sheet should be used in conjunction with the national community operations guideline for assessment, promotion and management of continence in adults 2019.

STEP 1: For adults presenting with bladder & bowel dysfunction the RN completes bladder & bowel assessment form. Obtain consent for data collection from client to have the assessment shared with other members of the MDT. Ensure privacy for patient during assessment.

During assessment detail any physical, sensory or intellectual disability and consider A, B,C below

A-Medical details

Record all medical, surgical and obstetric history.
Medications: Current and record any allergies

B-Contributory factors:
Assess mobility,
cognitive impairment,
manual dexterity,
skin integrity,
Lifestyle, e.g smoking cessation,
communication difficulties,
environmental factors, e.g access to toilet facilities,
social circumstances

C- Fluid intake see step 3

Toileting pattern

TIP: Bladder& bowel assessment form available at www.hse.ie/continencecare

Presenting continence problem

Allow client to describe symptoms in their own words. Where the person is unable to provide details due to a cognitive impairment or intellectual disability, the carer/professional caring for them may provide details of symptoms and history. Discuss symptoms and how it impacts their daily life.

STEP 2: Urinary assessment: the symptoms should identify the possible cause of bladder dysfunction. There may be more than one cause. If **clinically indicated** refer to Medical Practitioner.

STEP 3: Bowel assessment. Client, carer or RN completes bladder & bowel record chart for 72 hours. Use Bristol stool chart to record type of stool. **Refer to bowel assessment pathway.**

TIP: Bladder & bowel record chart and instructions available at www.hse.ie/continencecare

STEP 4: Instigate conservative management

Stress incontinence
- Treat constipation
- Treat chronic cough
- Reduce weight
- Fluid intake 1.5-2L daily unless medically contra-indicated
- HSCP referral for further assessment e.g physio, OT, dietitian
- Pelvic floor exercises

Urgency incontinence
- Fluid intake 1.5 - 2L daily unless medically contra-indicated
- Reduce caffeine intake & other stimulant drinks
- Bladder retraining
- Pelvic floor exercises
- Treat constipation
- Reduce weight
- Smoking cessation
- HSCP referral for further assessment e.g physio, OT, dietitian
- Medication review
- GP referral

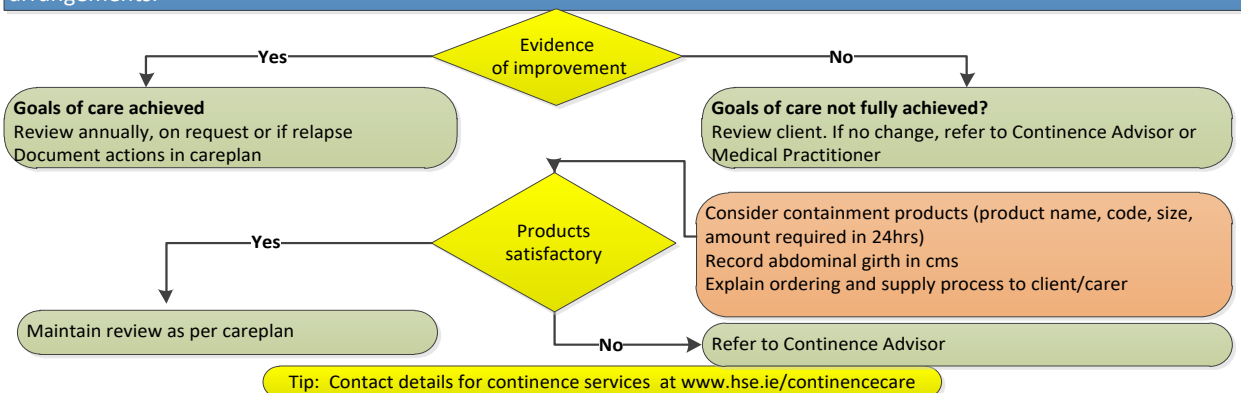
Mixed incontinence

As per treatment for stress incontinence and urgency

Functional incontinence
- Make toileting easier
- Improve access to toilet
- Provide toilet substitute
- Toilet prompting
- Timed voiding for clients with confusion
- Clothing adaptations

Overflow
- Reduce caffeine intake
- Fluid intake 1.5-2L daily unless medically contra-indicated
- Refer to GP/ Continence Advisor for further investigation & definitive diagnosis

STEP 5: Care plan devised by RN in consultation with client. If continence containment product required forward completed order form to relevant CHO data inputter/ continence advisor/CNS/ADPHN/ or as per local practice arrangements.



Tip: Contact details for continence services at www.hse.ie/continencecare

STEP 6: Repeat assessment must be carried out annually or earlier if there is a change in client's condition. The assessment should be completed face - to - face where possible.

TIP: FAQs are available at www.hse.ie/continencecare

Outline of steps for carrying out a baseline bowel assessment (level 1)

This reference sheet should be used in conjunction with the national community operations guideline for assessment, promotion and management of continence in adults by registered nurses 2019

STEP 1: For adults presenting with bowel dysfunction the RN completes bowel part of bladder & bowel assessment form. Obtain consent for data collection from client to have the assessment shared with other members of the MDT. Ensure privacy for patient during assessment.

During assessment consider factors at A,B,C below:

A-Medical details
Medical, surgical and obstetric history
Medications
Allergies
Cognitive status

B-Predisposing factors:
Urinary incontinence, faecal incontinence, loose stool, constipation,
Pelvic prolapse, anal surgery,
Pelvic radiotherapy, peri-natal injuries/episiotomy, perianal itch
Neurological disease or injury
Inflammatory bowel diseases
Frail, learning disability.

C- Diet & lifestyle
Balanced diet and any existing therapeutic diets
Identify malnutrition using validated screening tool
Fluid intake
Toilet access
Correct positioning on toilet

TIP: malnutrition resources available at www.hse.ie/ nutritionsupports

Presenting bowel problem

Allow client to describe symptoms in their own words. Where the person is unable to provide details due to a cognitive impairment or intellectual disability, the carer/HCP caring for them may provide details of symptoms and history. Discuss symptoms and how it impacts their daily life.

TIP: Bladder& bowel assessment form available at www.hse.ie/continencecare

STEP 2: Bowel assessment. Client, carer completes bladder & bowel record chart for 72 hours. Use Bristol stool chart to record type/ consistency/amount of stool. The symptoms should identify the possible cause of bowel dysfunction. There may be more than one cause.

Red flag signs & symptoms: altered bowel habit, blood in stool, abdominal pain, unexplained weight loss, rectal pain or bleeding, severe persistent constipation, family history.
Refer immediately to medical practitioner for physical examination/ investigations.

STEP 3 : Instigate following management if client presents with diarrhoea, constipation, faecal impaction.

Constipation
Assess diet, fluid, exercise for predisposing factors- introduce changes if required

Advise on correcting position
Provide health education ie information sheets

Hard stool(Bristol 1-3) – oral laxative (faecal softener) prescribed by Medical Practitioner /ANP
Soft stool(Bristol 5-7) – oral laxative (faecal stimulant) as prescribed by Medical Practitioner/ANP

Reassess stool consistency and review care-plan accordingly
GP referral /medication review

Diarrhoea
Sudden onset e.g **infection (refer to IPC precautions)**, recent travel, food poisoning- observe vital signs & refer as to medical practitioner. Refer for stool sample.
Overflow associated with constipation/ impaction
Pre-existing medical/surgical conditions
Trigger foods
Overuse of laxatives or medication induced- offer education & advice on appropriate laxatives and diet

- Encourage adequate fluid intake
- Skincare advice
- Facilitate access to toilet
- Continue to monitor and assess client until symptoms have resolved
- Refer to medical practitioner if symptoms persist /medication review

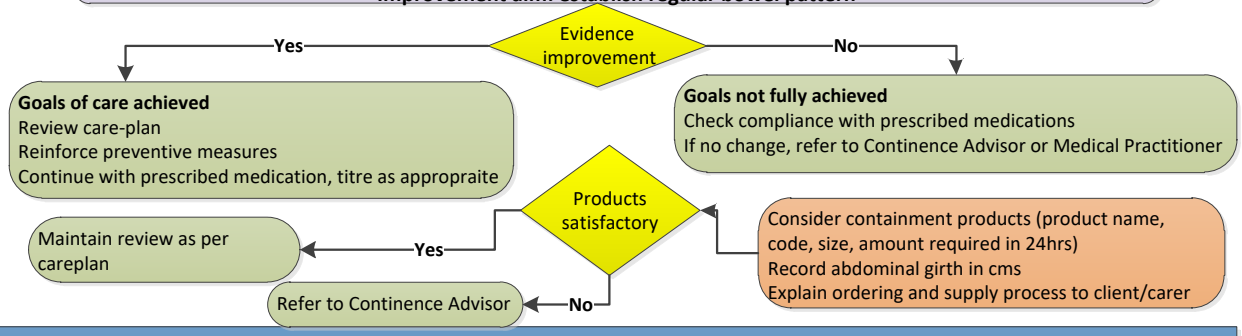
Faecal impaction
If symptoms suggest faecal impaction- refer immediately for medical assessment.

Hard stool - oral or rectal stool softening medication as prescribed by Medical practitioner/ANP.
Soft stool - oral or rectal bowel stimulant as prescribed by Medical practitioner/ANP.
Maintenance- aim to establish regular bowel habit (Bristol stool type 4)

Preventive measures

1. Fluid intake
2. Dietary intake
3. Mobility
4. Medication review
5. Access to toilet
6. Equipment
7. Privacy
8. Pain
9. Psychological issues
10. Medical condition

Improvement aim: establish regular bowel pattern



STEP 4: Repeat assessment must be carried out if there is a change in client's condition. The assessment should be completed face - to - face where possible. Documentation adhere to professional guidelines

References: NICE Faecal Incontinence in Adults clinical guideline 49 2007, reviewed June 2018 and unchanged

Term or abbreviation	Glossary of terms and abbreviations
Carers	The term carers is used in this document in line with government strategy, The National Carers' Strategy – *Recognised, Supported, Empowered (2016)* 'A carer is someone who is providing an ongoing significant level of care to a person who is in need of that care in the home due to illness or disability or frailty.'
CFS	Community Funded Schemes
CHO	Community healthcare organisation
CNS	Clinical nurse specialist
Containment products	References to continence containment products, nappies or pads are all used to denote the same thing. Containment products may be washable or disposable. Does not include urostomy or colostomy products.
Continence	The ability to store urine in the bladder or faeces in the bowel, and to excrete (empty) voluntarily where and when it is socially appropriate to do so (Getliffe & Dolmen 2007)
Conservative intervention	Conservative management of UI largely comprises physical, behavioural and psychological interventions, often delivered in combination (EAU , 2018).
Constipation	Is a condition in which there can be fewer than 3 bowel movements a week, or hard dry and small movements that are painful or difficult to pass (PPPG CA003 CHO8)
Diarrhoea	Three or more loose or liquid stools per day, or having more stools than is normal for that person (PPPG CA003 CHO8)
Faecal impaction	Is when the rectum and often the lower colon is full of hard or soft stool and the client is unable to evacuate the bowel unaided. This can result in impaction with overflow spurious diarrhoea(PPPG CA003 CHO8)
Functional incontinence	The bladder and bowel function normally but incontinence occurs due to a physical, mental or environmental barrier which prevents the person from identifying or getting to an appropriate place to toilet (Getliffe and Dolmen, 2007)
GP	General practitioner
HCP	For the purpose of this document Healthcare Professional (HCP) refers to ,

	Chartered Physiotherapist, Occupational therapist and Dietitican)
Healthcare record	Refers to all information collected, processed and held in both manual and electronic format, related to the client and their care. Includes demographics, unique health identifier, clinical data, images, investigations, samples, correspondence, and communications relating to the client and his/her care (HSE 2011)
HSE	Health Service Executive - the public health service in Ireland, responsible for providing health and personal social services to the population.
Incontinence	The generic term incontinence is interchangeable with the terms 'bladder and bowel difficulties', 'bladder and bowel dysfunction' or 'wetting and soiling problems'
Incontinence associated dermatitis (IAD)	A type of irritant contact dermatitis (inflammation of skin) found in people with urinary and or faecal incontinence (Global IAD Expert Panel, Wounds International (2015) *Best Practice Principles Incontinence Association Dermatitis Moving Prevention Forward.* London.)
PPPG	Policy, procedure, protocol, guideline
Physiotherapy	Physiotherapy involves using knowledge and skills unique to physiotherapists and is the service only provided by, or under the direction and supervision of, a physiotherapist. (EAU guidelines 2018)
Overactive bladder (OAB) (OAB, Urgency)	Overactive bladder (OAB) is defined as urgency that occurs with or without urgency UI and usually with frequency and nocturia. OAB that occurs with incontinence is known as 'OAB wet'. OAB that occurs without incontinence is known as 'OAB dry'. These combinations of symptoms are suggestive of the urodynamic finding of detrusor overactivity, but can be the result of other forms of urethrovesical dysfunction. (NICE 2018)
Urinary incontinence (UI)	Is the involuntary loss of urine and can be caused by a number of different conditions (Haylen, 2010). UI may occur as a result of a number of abnormalities of function of the lower urinary tract or as a result of other illnesses, which tend to cause leakage in different situations. There are three main types of UI: <u>Stress urinary incontinence</u> is the complaint of involuntary loss of urine on effort or physical exertion (e.g sporting activities) (Haylen, 2010). Stress UI is a symptom rather than a condition.

	Urgency urinary incontinence: is involuntary urine leakage accompanied or immediately preceded by urgency (a sudden compelling desire to urinate that is difficult to delay). (NICE, 2018). Mixed urinary incontinence: is the complaint of involuntary loss of urine associated with urgency and also with effort or physical exertion or on sneezing or coughing (Haylen, 2010).
Urinary continence assessment	For the purpose of this nursing guideline a urinary continence assessment is defined as, 'an active process of determining a patient's bladder habits and patterns; identifying the changes needed to improve function; and after exploring options to achieve the changes, choosing an appropriate treatment plan' (Winder, 2001).
Overflow	Overflow urinary incontinence occurs when the patient experiences an involuntary release of urine from an overly full urinary bladder, often in the absence of any urge to urinate (Barrie 2015).
RN	Registered Nurse – Includes all Registered Nurses (RPHNs, RGNs, RPNs, RSCNs, RNIDs) whose names are entered in the Live Register of Nurses as provided for in Section 27 of the Nurses Act 2011 and held by the Nursing and Midwifery Board Of Ireland
Residential care settings	Public, private or voluntary services providing some or all of the following for older people: long-term care, respite, rehabilitation, or convalescence (HIQA 2009).
Toileting	1. Using a toilet; defecation and urination 2. Helping a client with defecation and urination
Timed Voiding/Toileting	Timed voiding/ toileting is a fixed time interval toileting assistance program that has been promoted for the management of people with urinary incontinence who cannot participate in independent toileting
Voiding diaries (frequency charts)	Voiding diaries are a semi-objective method of quantifying symptoms, such as frequency of urinary incontinence episodes. They also quantify urodynamic variables, such as voided volume and 24-hour or nocturnal total urine volume. They are also known as micturition time charts, frequency/volume charts and bladder diaries. (EAU, 2018).
Voiding problems	Voiding problems include symptoms of straining, slow or weak stream, hesitancy, feeling of incomplete emptying, and post-micturition dribble. These symptoms are commonly associated with outlet obstruction, underactive detrusor activity, benign prostate hyperplasia (BPH), urethral trauma, urethral stricture, or other bladder or lower tract pathology.

	(Staskin and Kelleher, 2009)

1.0 Assessment of continence

Assessment of continence is based on individual need, using a nursing assessment tool with client consent. In order to provide the client with the required health and social care, personal information is collected during the assessment. To comply with GDPR, this information is shared with healthcare professionals on a need-to-know basis only, to ensure the client receives a quality service.

1.1 Assessment of bladder and bowel continence is an intrinsic part of a holistic assessment of the client. The assessment is undertaken by RN (registered nurses) who have received education and training on continence management for adults.

1.2 In order to fully understand the client's continence problems and needs, the first priority is to create an environment that ensures maximum privacy and opportunity for open discussion, ideally in the comfort of the client's own home or health centre or relevant setting (Holmes et al., 2002).

1.3 The assessment of clients with conditions such as learning disabilities, dementia or frailty can be challenging and needs to be undertaken with due care and sensitivity. However, as with other clients, the assessment must be undertaken in order that the appropriate treatment and management of their conditions can be put in place. If required, refer to Physiotherapist or Occupational therapist for assessment for mobility rehabilitation, walking aids or dressing/undressing aids.

1.4 The assessment form for bladder and bowel function (appendix V) is completed in conjunction with the client, carer, or family as appropriate. Permission to seek information from carers or family should first be agreed with the client, as appropriate.

1.5. To establish a client's usual pattern of voiding and bowel movements, the type and amount of fluid intake and wetting accidents, a three day bladder and bowel record chart (appendix VI) should be completed. This should be sufficient to establish a baseline but a longer period may be necessary, or charting may need to be repeated, depending on client need. The Bristol stool chart is used with the bowel record chart to get a baseline for bowel function.

1.6 A bladder and bowel continence assessment may require several visits to ensure all necessary information is gathered (Gettliffe & Dolmen, 2007).

1.7 When incontinence is identified, the findings should be documented in the client's record. Where possible the findings should include a diagnosis on the type of incontinence (such as overactive bladder, stress, urgency incontinence or overflow functional incontinence). If there is uncertainty about the type of incontinence, the need for onward referral should be

discussed with the client, carer or family if appropriate, and a referral made to the relevant available service, such as GP, physiotherapist, continence advisor. A copy of the continence assessment, the bladder and bowel record chart, continence care plan, and the outcome of interventions tried prior to referral, should be included with the referral. (appendix VIII for referral form).

1.8 The assessing RN should provide information along with education to the client, and family (if appropriate), on interventions which may help improve their incontinence. These include lifestyle changes (diet, fluid intake, and exercise), bladder retraining, and the best toilet sitting position in order to encourage bowel opening. For pelvic floor exercise referral to physiotherapist or continence advisor trained in pelvic floor assessment if available. Copies of information leaflets should be given to the client, carer, or family as appropriate and record in care plan.

1.9 If the assessment indicates the need for continence products, the steps outlined in section 2.0 below should be followed.

1.10 A review assessment should be carried out at least once every year. This should be done using the appropriate repeat assessment form (appendix VII). A review should also be carried out if the client's needs change or, following completion of a course of treatment (Association for Continence Advice UK, 2017). This review assessment should be agreed with the client, carer, or family as appropriate. Clients should also be advised to contact their RN if their continence needs change

1.11 All interventions, review dates, and referral pathways should be documented in the client records in accordance with NMBI guideline on recording clinical practice to nurses and midwives 2015.

2.0 Provision of continence containment products for bladder and/or bowel dysfunction

Provision of products is not first-line treatment.

In line with best practice, assess the client for conservative management and lifestyle changes that can improve continence. The assessment should identify the client's suitability for items that assist in preserving continence before considering the prescription of continence containment products. These items include hand-held urinals, urinary sheaths, raised toilet seat, or commode. These may be more acceptable to the client and prevent the need for continence containment products.

2.1 Continence containment products should only be provided:

- after completing a continence assessment
- following provision of relevant advice and education to the client on the management

of incontinence, and implementing appropriate interventions such as fluid review, diet review, pelvic floor exercises or physiotherapy and timed toileting

- where there is clear indication of the need for these products

2.2 There should be due consultation with the client, carer or family (as appropriate), on all aspects of the continence assessment, including identifying the most appropriate disposable product from the list of products. This should be documented in the client records.

2.3 Only continence containment products specifically manufactured for the purpose should be used for bowel and/or bladder dysfunction. Items such as disposable procedural incontinence sheets are for use during bowel procedures only and should not be routinely used in the management of incontinence.

2.4 Continence containment products are classified as medical devices (Dept. of Health UK, 2000) and should be monitored as such. The RN should complete the relevant order form, and follow the defined process for the provision of these products (appendix IX).

2.6. All sections of the order form must be completed. The order form should also document the quantity of product required on a daily basis (per 24 hours).

2.7. If required, clients are generally provided with 1 – 4 products per 24 hours, based on their assessed need. Products are provided from the core range of contracted products which is designed to cater for the needs of the vast majority of clients.

2.8. Contracted products not on the core list should only be ordered where there is a clear clinical need. These products require the approval of the DPHN, ADPHN or continence nurse advisor as agreed locally.

2.9 Each continence order form - whether an initial order or a revised order - must reflect the client's total continence product requirements for a 24-hour period. Each new or revised order is inputted into the ordering database and informs all future orders for each patient.

2.10. Manufacturer fitting guides must be followed. The RN who orders the product must educate the individual client, carer, or family (as appropriate). This should be documented in the client records.

2.11 The RN who orders the product should give supportive educational information on the specified product to the client, carer or family (as appropriate). This should be documented in client records. This information is available at www.hse.ie/continencecare

2.12 Skin care:

2.12.1. The RN must provide the client, carer, and family (as appropriate), with information on maintaining good personal hygiene and skin care and record same.

2.12.2. The RN must advise the client, carer, or family (if appropriate), on the use of water-based barrier creams only (oil-based barrier creams are not recommended with the use of

continence wear), barrier creams, emollients and moisturising cream when using disposable continence products. Creams and emollients must be used sparingly. Excessive use can block the quick dry layer of the pad, which lies next to the skin. If the effectiveness of this protective layer is reduced, moisture can remain on the skin and increase the risk of incontinence-associated dermatitis (IAD) and skin breakdown.

2.12.3. Talcum powder should not be used with continence containment products**.** It absorbs urine or perspiration and can increase the risk of fungal infection, particularly in skin folds and groin area (Getcliffe & Dolmen, 2007).

2.13 The RN will reassess the suitability of the products, based on client need, at least annually**,** or earlier if there is a change in the client's needs (Association for Continence Advice UK, 2017).

2.14 The RN should carry out a patch test in line with manufacturers' guidelines if it is suspected that a client may have an allergy to the product. A patch test requires a small square of the product to be taped to the back of the shoulder for 24 hours. When it is removed the condition of the skin is observed. Redness around the area indicates intolerance to the product.

3.0 Best practice statements for the provision of products.

These statements assume that clinical assessment and first-line treatment has taken place, and the client has a clinical need for products.

All care settings

3.1. All clients with an identified continence problem must be offered a comprehensive clinical bladder and bowel assessment, with appropriate interventions undertaken and reviewed.

3.2. All clients should have an assessment before the RN decides on the appropriate treatment and management. The custom and practice of automatically providing products to clients (including those with an acknowledged disability) is not appropriate.

3.3. The registered healthcare professional remains accountable for the clinical assessment of continence and instigation of first-line treatment.

3.4. Containment products should not be supplied for treatable medical conditions (or for bodily fluids other than urine or faeces). If an individual has capacity and declines treatment, provision of products will not be offered as an alternative. Alternative collection devices should be considered, for example, prescription urinals, urinary sheaths and body worn urinals, bags and adaptive underwear (such as specialist briefs with adapted collection systems).

3.5. The number of products issued per 24 hours would normally not exceed four. In exceptional circumstances additional products may be required. (this should be based on bladder/stool diary , assessment and individualised requirements)

3.6. Products for faecal loss: Where a client presents with faecal loss only, a simple, rectangular pad should be recommended (super absorbent powder in the body of the pad is not necessary). Rectal irrigation and anal plugs may also be considered but must be prescribed by a doctor following an assessment.

3.7. The use of a two-piece system (a shaped pad and fixation pants or underwear) should be promoted where possible. For clients where this is not appropriate, the use of alternative styles may be necessary. All-in-one products should NOT be issued for clients who are able or capable of using a toilet or being toileted, and should not be supplied to inpatients or care-home clients where 24-hour care is available. The only exception to this is where toileting is clinically contra-indicated and provision of product is authorised by the continence nurse specialist or the budget holder.

3.8. Authorisation for bariatric products, maximum absorbency products (those over 1,100mls), belted products, and disposable pants, may be required from the continence nurse advisor or line manager with the approval of the budget holder.

3.9. RN involved in the transition of children and young people into adult services should be mindful of the need for continuation of continence care.

3.10. Where a client transfers between service areas, a reassessment should be carried out.

Acute hospital inpatient care and residential care settings

Hospital inpatient care: at times community clients will also be receiving care in the acute setting and the following best practice statements will be of benefit**.**

3.11. Where an elective surgical procedure is planned and carries the risk of incontinence post-operatively (such as prostate surgery), the RN should consult with, or refer the client to, the specialist continence services or physiotherapy prior to the surgery.

3.12. A client who is already receiving continence containment products should be encouraged to bring them in with them during a hospital stay

3.13. During their hospital stay, all clients with incontinence symptoms must have a baseline continence assessment completed and any first-line treatment started. In unresolved or more complex cases, referral should be made to inpatient continence services where appropriate.

If incontinence symptoms have not resolved before discharge home, client should be provided with sufficient supply until reassessment in the community, to ensure that they are not placed at immediate risk. The client's discharge letter to the community services should include a

copy of the continence assessment carried out in the hospital.

3.14. Inpatient services should have a standard product list aligned with the national HSE list in order to avoid confusion and changing products for clients and carers. The specialist continence service can advise in cases where a clinical assessment identifies a need for a product outside the list.

3.15. A comprehensive level 1 assessment must be undertaken before products are supplied to clients. Clients who are experiencing incontinence associated with an emergency inpatient hospital admissions during a period of acute illness, or clients who have a limited life expectancy (within six months) may be provided with products during that acute phase, on the understanding that a comprehensive assessment will be undertaken once their acute episode has stabilized.

Residential care settings

3.16. Clients in HSE residential care settings should receive assessment, treatment and products from the HSE to ensure quality and equity. In nursing homes the assessment is carried out by nursing home registered nurses and forwarded to the HSE continence advisor (or appropriate person as per local protocol) for initial review and advice.

3.17. Where clients in nursing homes are in receipt of HSE products, the nursing home must co-operate with periodic audits by the HSE to ensure that residents' clinical needs are being met, as well as to ensure efficient use of HSE-funded products. These audits also help to identify staff training that may be required to support residents with continence problems.

End of life

3.18. End of life continence care is usually aimed at promoting continence but the approach may change during the period when death is imminent, and life expectancy is limited to a short number of days. At the end of life, continence care should be based on patient wishes and preferences. Care should be directed at maintaining comfort and dignity and relieving symptoms.

PART B: PPPG DEVELOPMENT CYCLE

1.0 INITIATION

1.1 Purpose

1.1.1 To set out the HSE national guideline for the nursing assessment, promotion and management of continence care and provision of containment products to clients over 18 years. To ensure referral to relevant HSCP for specialist

management of incontinence.

1.1.2 To provide a standardised approach to continence care and the provision of containment products to clients by reducing variation in current practice.

1.1.3 To ensure all clients have access to an equitable service.

1.2 Scope

1.2.1 This guideline relates to all adults aged 18 years and over and healthcare professionals involved in their care.

1.2.2 It applies to all RN's who have received education and training on continence management for adults.

1.2.3 This national guideline replaces existing local policies and procedures.

1.3 Objectives(s)

1.3.1 To provide clear guidance for healthcare professionals undertaking bladder and bowel assessments for adults with continence care needs.

1.3.2 To provide clear guidance for RN's, managers and staff involved in promoting continence care and approving products for clients and their carers or families.

1.4 Outcome(s)

1.4.1 All adults with continence care needs will have a comprehensive evidence-based bladder and bowel assessment undertaken by appropriately trained RN and will be provided with an individualised plan of care as most appropriate.

1.5 PPPG development group

See appendix II for membership of the PPPG development group and appendix III for conflict of interest declaration form.

1.6 PPPG governance group

See appendix IV for membership of the approval governance group.

1.7 Supporting evidence

- Cochrane database of systematic reviews (2016) Conservative interventions for urinary incontinence in women: an overview of Cochrane systemic reviews issue 9. Art no: CD012337 published by John Wiley & sons, Ltd.

- EAU Guidelines (2018) Edn presented at the EAU Annual Congress Copenhagen ISBN 978-94-92671

- NICE (2007) Faecal incontinence in adults: management Clinical guideline [CG49] Published date: June 2007 (Reviewed in June 2018. Found no new evidence that affects the recommendations in this guideline).

- NICE (2013) Urinary incontinence in women: management Clinical guideline [CG171] Published date: September 2013 Last updated: November 2015. (Reviewed the evidence in March 2016 and are currently updating the recommendations on surgical approaches for stress urinary incontinence and

extending the scope to include pelvic organ prolapse. See the guideline in development page for progress on the update.)

Legislation and other related polices are outlined

- Nursing and Midwifery Board of Ireland (2014), The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives
- Nursing and Midwifery Board of Ireland (2015), Scope of Nursing and Midwifery Practice Framework
- Nursing and Midwifery Board of Ireland (2015), Recording Clinical Practice , Professional Guidance to Nurses and Midwives
- Health Information and Quality Authority (2012), National Standards for Safer Better Healthcare
- HSE Safeguarding vulnerable persons at risk of abuse (2014)
- Assisted Decision Making (Capacity) Act 2015. Under the act persons lacking capacity or with limited capacity will have a right to have legally recognised decision makers support their decision making, or where capacity is lacking to substitute their decision making.

2.0 DEVELOPMENT OF PPPG

2.1 Clinical question

Urinary incontinence is an extremely common complaint worldwide. Its impact causes a great deal of distress and embarrassment as well as significant costs on a human and economic level. In Ireland there is no statutory requirement to provide containment products for incontinence, so each CHO has developed their own policy and guidelines. As a result, there is a wide variation of access to the provision of containment products resulting in cost pressures and disproportionate distractions from best clinical practice.

The development group reviewed current best practice in each CHO area in Ireland. The group's objective was to establish evidence of best nursing practice in the promotion of continence care to adults.

The definition used for 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.

In Ireland the Leas Cross report (a review of deaths in a nursing home from 2002 -2005) noted poor standard of continence care. This included a percentage of patient complaints of:

- inappropriate use of incontinence pads
- general personal hygiene was poor

- number of patients having a strong odour of incontinence

The Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) highlighted poor client 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 clients requesting assistance
- patients being left in soiled sheets
- patients being left on commodes
- uncaring and unsympathetic attitude of staff

2.2 Literature search strategy

The search terms included nursing care in urinary continence. It yielded a recently published UK consensus document. This document sets out current nursing best practice in the UK and was undertaken by the Association for Continence Advice (ACA 2017). A further search revealed a Cochrane database of systematic reviews (2016) Conservative interventions for urinary incontinence in women: an overview of Cochrane systemic reviews issue 9. Art no: CD012337 published by John Wiley & sons, Ltd and NICE faecal incontinence guideline 49 2007, reviewed June 2018 and unchanged.

2.3 Method of appraising evidence

The UK nursing consensus guidance document and CHO practice guidance documents were reviewed and the results were deemed applicable to the development group's objective. Other practical evidence based guidance on the clinical problem of UI was found in the European Association of Urology (2018) guidelines.

A draft guideline was developed and once it received majority approval from the development group, it was sent for stakeholder review. This included internal staff (nursing, physiotherapy, heads of service) working in each CHO area and Acute Hospital division. External stakeholders' were relevant patient advocacy groups and professional bodies (Continence Foundation Ireland and Irish Society of Chartered Physiotherapists) and the HSE National Practice Development Co-ordinator for PHN services in the office of the Nursing and Midwifery Service Director (ONMSD). Suggested amendments were reviewed by the development group and consensus reached to accept or reject.

2.4 Process used to formulate recommendations

The PPPG development sub-group reviewed the UK consensus document and are satisfied that it has been peer reviewed and is evidence-based. It fulfilled the need in

relation to providing clear guidance to the current approach to promoting continence care and product provision within the HSE.

2.5 Summary of the evidence from the nursing literature (sourced from UK Guidance for the provision of containment products for adult incontinence. A consensus document 2017 Association for Continence Advice).

In this document there is significant reference to **clinical assessment, ensuring that conservative management has taken place, and that the client has a clinical need for product provision.** It further references best practice statements and the development group agreed to adopt these for use in this guideline. Clinical assessment is a critical component in the diagnosis of the cause(s) of incontinence and should be followed by treatment opportunity before considering containment products.

Summary of evidence and recommendations from EAU (European association of urology 2018)

Summary of evidence	**Recommendation**
Patient assessment questionnaires: To date there is no one questionnaire that fulfils all requirements for assessment of people with UI. Clinicians must evaluate the tools which exist, for use alone or in combination, for assessment and monitoring of treatment outcome.	Use a validated and appropriate questionnaire when standardised assessment is required.
Voiding diaries: of three to seven days duration are a reliable tool for objective measurement of mean voided volume, day and night time frequency and incontinence episode frequency.	Ask patients with UI to complete a voiding diary when standardised assessment is needed. Use diary duration of at least three days.
Urinalysis Urinalysis negative for nitrite and leucocyte esterase reliably excludes UTI. UI may be a symptom during UTI. The presence of a symptomatic UTI worsens symptoms of UI. Elderly nursing home patients with UI do not benefit from treatment of asymptomatic bacteriuria.	Perform urinalysis as part of the initial assessment of a patient with UI. If a symptomatic UTI is present with UI, reassess the patient after treatment. Do not routinely treat asymptomatic bacteriuria in elderly patients to improve UI.
Constipation: several studies have shown strong associations between constipation and UI. Constipation can be improved by behavioural, physical and medical treatments.	Adults with UI who also suffer from constipation should be given advice about bowel management in line with good medical practice.
Lifestyle interventions: examples of lifestyle	Encourage overweight and obese adults with

factors that may be associated with incontinence include obesity, smoking, level of physical activity and diet. Modification of these factors may improve UI.	UI to lose weight and maintain weight loss Advise adults with UI that reducing caffeine intake may improve symptoms of urgency and frequency but not incontinence Review type and amount of fluid intake in patients with UI Provide smoking cessation strategies to patients with UI who smoke
Bladder training (BT): is effective for improvement with UI in women. The effectiveness of BT diminishes after the treatment has ceased. BT is better than pessary alone. Prompted voiding, either alone or as part of a behavioural modification programme, improves continence in elderly, care dependent people.	Offer prompted voiding for adults with UI who are cognitively impaired. Offer bladder training as a first-line therapy to adults with UUI or MUI
Pelvic floor muscle training (PFMT) Pelvic floor muscle training (PFMT) for women with UI. Pelvic floor muscle training is better than no treatment for improving UI and quality of life in women with SUI and MUI. PFMT commencing in the early postpartum period improves UI in women for up to twelve months. Pelvic floor muscle training for post prostatectomy UI. This training appears to speed the recovery of continence following radical prostatectomy. It does not cure UI in men post radical prostatectomy or transurethral prostatectomy.	Offer supervised intensive PFMT, lasting at least 3 months as a first line therapy to all women with SUI or MUI (including elderly and post natal). Offer instruction on PFMT to men undergoing radical prostatectomy to speed recovery from UI. Ensure PFMT programmes are as intensive as possible.
Conservative therapy in mixed urinary incontinence (MUI) Pelvic floor muscle training appears less effective for MUI than for SUI alone.	Treat the most bothersome symptom first in patients with MUI.

2.6 Resources necessary to implement the PPPG recommendations

Changing practice must be supported by education and so an education programme is designed to implement this guideline. The education programme is designed in consultation and with the involvement of the Centre for Nursing Midwifery Education (CNME's).

Additional resources, where required, will be sought through local training needs

analysis and the HSE service planning process. The main costs for the implementation of this guideline are the costs associated with structured training for staff. It is critical that staff involved in continence promotion have the knowledge and training to assess clients appropriately.

2.7 Safeguarding

All healthcare professionals have a duty to safeguard the wellbeing of clients. If they become aware of any concerns, they should seek advice and take appropriate action by relaying their concern to the designated officer within their service. A full contact listing of the HSE safeguarding teams is available on at https://www.hse.ie/eng/services/list/4/olderpeople/elderabuse/protect-yourself/safeguarprotectteams.html

3.0 GOVERNANCE AND APPROVAL

3.1 Formal governance arrangements

The governance and approval arrangements rest with the CFS incontinence wear, urinary ostomy and bowel care group. The group reviews and signs the PPPG checklist and recommends it to the CFS governance group. Refer to appendix IV for membership of this group.

The final document is submitted to the National Director Community Operations. Once approved the final version is converted to a PDF document to ensure the integrity of the PPPG. A signed and dated master copy is retained within National Community Operations.

3.2 Method for assessing the PPPG in meeting the standards outlined in the HSE national framework for developing PPPGs

The checklist accompanies the final draft on submission to the CFS Governance group for approval. The checklist is used in assessing the PPPG in relation to meeting the standards outlined in the HSE national framework for developing PPPGs.

3.3 Copyright and permission

Permission was sought and gratefully received from the author (Sharon Eustice, UK nurse consultant) to adopt contents of the UK consensus document to inform this guideline. Copyright owner reference is - Guidance for the provision of containment products for adult incontinence: A consensus document 2017, Association for Continence Advice.

4.0 COMMUNICATION AND DISSEMINATION

The guideline is published on www.hse.ie/continencecare. RN's are made aware of the guideline through HSE and CHO communication mechanisms, the Office of Nursing & Midwifery Services Directorate, nursing forums and other relevant outlets. A communication and dissemination plan is endorsed by the CFS governance group.

5.0 IMPLEMENTATION

5.1 The guideline should be adopted by HSE staff from the date of publication. Sample tools to assist in implementing this guideline are outlined in appendices. The guideline does not replace the clinical judgement of a qualified healthcare professional. Where there are concerns regarding a client, staff should refer to their relevant line manager or specialist.

5.2 Education required implementing the PPPG

An education programme is designed in consultation with the Centre for Nursing Midwifery Education (CNME) to implement this guideline. The programme will be rolled out through the CNMEs with the support of the directors of nursing and continence advisors from each CHO area.

Resources required:

- guideline and supporting tools available in an online toolkit format
- training pack with supporting practical resources

5.3 Specific roles and responsibilities

5.3.1 The chief officer in each CHO is responsible for:

- supporting the implementation and ongoing evaluation of the guideline
- assigning personnel with responsibility, accountability and autonomy to implement the guideline
- monitoring the implementation of the guideline
- supporting ongoing education and evaluation to support the guideline, as well as any actions required following the evaluation

5.3.2 Director of public health nursing (DPHN) in each CHO area and all other relevant directors of nursing are responsible for ensuring all relevant nursing staff receive education and training on continence promotion and management.

5.3.3 Service manager in each CHO area is responsible to ensure all other relevant staff receives education and training on continence management as appropriate.

5.3.4 It is intended that this guideline will assist all RN's in their practice. Staff should adhere to their professional scope of practice guidelines and maintain competency. In using this guideline RN's must be aware of the role of appropriate delegation. Please see appendix I, for a copy of the signature sheet, which should be signed to show users have read, understand and agree to adhere to this guideline. The relevant line manager is responsible for ensuring that staff under their direction having read and signed.

6.0 MONITORING, AUDIT AND EVALUATION

6.1 Lead person(s) responsible for the following process:

6.1.1 **Monitoring:** Each CHO area should implement a systematic process of gathering information and tracking over time to achieve the objectives of this guideline.

6.1.2 **Audit:** Implementation of the guideline must be audited in order to ensure that the guideline positively impacts client care. Suggested audit topics:

- Bladder and bowel assessment
- Bladder and bowel record chart

6.1.3 **Evaluation:** In relation to implementation of this national guideline a mechanism to measure the following should be considered:

- Number of clients, by setting, who are accessing the continence service each year
- Number of clients who were suitable to be referred to physiotherapy
- Number of clients who were not able to access a physiotherapy service
- Age of clients who are referred to the continence service for assessment for toilet training and / or provision of containment products
- Number of clients referred for containment products who are diagnosed with, or referred for further assessment of, bladder or bowel conditions that were previously not recognised in that individual
- Number of clients, categorised by age, provided with containment products
- Number of clients categorised by diagnosis or condition who are provided with containment products
- Number of clients referred to the continence service who have not been provided with products, but have achieved continence each year
- Cost of product provided to each client in each CHO area
- Client and / or carer satisfaction with the service
- Benchmarking against another CHO area

7.0 REVISION AND UPDATE

7.1 Procedure for the update of the PPPG

This guideline should be reviewed three years from date of issue.

7.2 Method for amending the PPPG if new evidence emerges

In the event of new supporting evidence identified by findings from audit and evaluation, scope of practice changes or advances in technology the national expert clinical continence group for provision of products will review the new evidence and amend and update as necessary.

8.0 REFERENCES

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products for adult incontinence

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Getliffe K. & Dolmen M. (2007) Promoting Continence, A Clinical and Research Resource. 3rd Edition. Edinburgh, Balilliere Tindall

Holmes J., Irwin B., Rigby D. & Wells M. (2002) Continence Link and Professional partnership in Continence Care. Educational Pack, produced by Galen.

Leas Cross Report available at
https://www.hse.ie/eng/services/publications/olderpeople/leas-cross-report-.pdf

Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive summary. Retrieved from http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf

NICE (2007) Faecal incontinence in adults: management Clinical guideline [CG49] Published date: June 2007 (Reviewed in June 2018.Found no new evidence that affects the recommendations in this guideline).

NICE (2013) Urinary incontinence in women: management Clinical guideline [CG171] Published date: September 2013 Last updated: November 2015. (Reviewed the evidence in March 2016 and are currently updating the recommendations on surgical approaches for stress urinary incontinence and extending the scope to include pelvic organ prolapse. See the guideline in development page for progress on the update.)

Regional continence advisory service, Midlands Louth Meath CHO8 (2018) Management of bowel dysfunction in adults CA003 No. 3.

9.0 APPENDICES

Appendix I	Signature sheet
Appendix II	Membership of the PPPG development group
Appendix III	Conflict of interest declaration form
Appendix IV	Approval of Community Funded Schemes governance group
Appendix V	Baseline (Level 1) assessment and management of bladder and bowel function form
Appendix VI	Bladder and bowel record chart and Bristol stool form scale
Appendix VII	Audit tool
Appendix VIII	Process for provision and delivery of containment products

Appendix I:
Signature sheet

I have read, understand and agree to adhere to this guideline:

Print name	Signature	Area of work	Date

Appendix II:

Membership of the PPPG development group; National Expert Clinical Advisory Group on Promotion of continence care to adults

Dr Fergal Flynn (Chair), National Lead CFS SIP Michelle Quinn, Healthy Bladder and Bowel Nurse, CHO 1 Margaret Tiernan, Continence Advisor, CHO 2 Ann O' Farrell, Continence Advisor, CHO 3 Rachel Long, Continence Advisor, CHO 4 Kathleen Dempsey, Continence Advisor CHO 5 Breda Moore, Continence Advisor, CHO 5 Maeve Smyth, Interim Director of Public Health Nursing, HSE, Community Health East, Wicklow CHO 6 Anna Marie Mills, Continence Advisor, CHO 8 Bridget Hayes , Continence Advisor, Dublin Mary Heslin, Continence Advisor, Dublin Una McCarthy, Standards Lead, Service Improvement Programme, Community Operations	Signature: _____ Date: _____

Appendix III: Conflict of interest declaration form (template)

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Conflict of interest declaration

This must be completed by each member of the PPPG Development Group as applicable.

Title of PPPG being considered:

Guideline on the promotion of continence care and provision of continence products to adults

Please circle the statement that relates to you:

1. I declare that I DO NOT have any conflicts of interest.
2. I declare that I DO have a conflict of interest.

Details of conflict (please refer to specific PPPG)

_____

_____

_____

(Add additional pages to this statement if required)

Signature: _____

Print name: _____

Chair

Registration number (if applicable): _____

Date: _____

The information provided will be processed in accordance with data protection principles as set out in the Data Protection Act. Data will be processed only to ensure that committee members act in the best interests of the committee. The information provided will not be used for any other purpose.

Appendix IV:

Membership of the approval governance group

Approval of Community Funded Schemes governance group

Dr Fergal Flynn National Lead, Community Funded Schemes	Signature: _____ Date: _____
Frank Murphy Head of Primary Care, CHO 2	Signature: _____ Date: _____
Loraine Kennedy Head of Primary Care, CHO 5	Signature: _____ Date: _____
AnnaMarie Lanigan Head of Primary Care, CHO 6	Signature: _____ Date: _____
Joe Ruane Head of Primary Care, CHO 8	Signature: _____ Date: _____
Des O'Flynn Head of Primary Care, CHO 9	Signature: _____ Date: _____
Chairperson: Siobhan McArdle Head of Operations: Primary Care Community Operations	Signature: _____ Date: _____

Appendix V – Baseline (Level 1) assessment of bladder and bowel function (adapted from CHO8)

Part 1

Name: _____ Date of birth: _____ Gender: _____

Address: _____

Eircode: _____ Phone: _____ Mobile: _____

Contact person and relationship to client: _____ Mobile: _____

GP name: _____ Address: _____

GMS (medical card) number: _____

Client consents to: **Data collection** Yes □ No

Nursing assessment Yes □ No □

Presenting continence problem			
When did it start?			
Treatment history			
History of urinary catheter	Yes	No	
Incontinence occurs	During the day	At night	
Degree of incontinence	Light (damp)	Moderate (wet)	Heavy (change clothes)
Is the problem causing	Anxiety	Low mood	Restricting activities, social interactions

Part 2

Disability (if any)		
In residential care?	Yes	No
Relevant medical, surgical or obstetric history BMI: _____		
Contributory factors (please comment):		
• Mobility impairment		

• Cognitive impairment		
• Communication impairment		
• Manual dexterity		
Daily fluids (type & amount)		
Toileting pattern	Independent □ Needs assistance □	Detail specific toileting accessibility problems
List current medication including medications that impacts on bladder and bowel function, e.g. diuretics, anti-depressants, BP meds, etc. Allergies:_____		

Part 3 Urinary assessment: (for all clients who have attained toileting skills)	**Possible cause**
Do you leak when you: laugh ☐ sneeze ☐ exercise ☐ get up from a chair? ☐	Stress incontinence
Do you have: An urgent need to use the toilet? Yes ☐ No ☐ Difficulty delaying passing urine? Yes ☐ No ☐ Sometimes leak before you reach the toilet? Yes ☐ No ☐	Overactive bladder, urge incontinence
How frequently do you visit the toilet? Does the bladder wake you at night? Do you ever wake with the bed wet?	Urgency/Overactive bladder (>8 per day and >1 at night) Retention with overflow
Does your bladder still feel full after passing urine? Yes □ No □ Do you sometimes have difficulty passing urine, Yes □ No □ e.g. having to wait or strain? Do you have a weak urine flow? Yes □ No□ Do you have pain on passing urine? Yes □ No □ Do you have frequent urine infections? Yes □ No □	Retention with overflow or outflow Obstruction
Urinalysis: Yes □ No □ **Date:** _____ **If urinalysis is abnormal refer client to GP** Yes □ No □ **Date referred:**	

Form completed by: _____ Title: _____ Date: _____

Part 4. Bowel assessment (please circle as relevant and give details where needed): Client name: _____ D.O.B. _____
How often do your bowels open?
Do you suffer with constipation? Yes ☐ No ☐ Diarrhoea: Yes ☐ No ☐ New Onset: Yes ☐ No ☐
Do you have any faecal incontinence? Yes ☐ No☐ Does this: occur on way to toilet? Yes ☐ No ☐ After a bowel motion? Yes☐ No☐
Do you ever soil without knowing? Yes☐ No☐ Do you have difficulty controlling wind? Yes ☐ No ☐ Bristol Stool Scale – Type of stool: _____
Do you use Laxatives? Yes ☐ No ☐ Laxative type and dose if relevant:
Has your bowel pattern changed? Yes ☐ No ☐
Do you have difficulty controlling your bowel motion? Yes ☐ No ☐
Have you noticed blood on stool on defecation: Yes ☐ No ☐
Do you experience any pain on defecation? Yes ☐ No ☐
Stoma Yes ☐ No ☐ Details:
Further information - pelvic prolapse visible Yes ☐ No ☐
Skin condition (groin / buttocks): Healthy □ Red □ Excoriated □ Other (specify): □ _____
Complete a Bladder & Bowel Record Chart for 3 days. Date commenced: ____ / ____ / _____

Part 5: Summary of registered nurses assessment and comments:

_____

_____

_____

_____

Part 6: Give details of management and care plan:

Fluid review Yes ☐ No ☐ Diet review Yes ☐ No ☐

Toileting Yes ☐ No ☐ Pelvic floor exercises Yes ☐ No ☐

Is client confident doing exercises correctly and knows how to progress them?
If not, refer to physiotherapist or Continence Advisor trained in PFMT.

Bladder retraining Yes ☐ No ☐ Toileting aids required Yes □ No □

Information leaflets given Yes ☐ No ☐

Anatomy and physiology of continence and treatment options discussed? Yes ☐ No ☐

Care plan developed with client or relevant person: Yes ☐ No ☐

Care plan discussed and agreed with the client: Yes ☐ No ☐

Referral to GP for OAB / UI medication following six week bladder retraining, if no improvement.

Part 7: Give details of continence containment products (if required):

Provide details of product code and amount required _____

_____ Abdominal girth measurement _____ cms

Client informed of the system and processes for home delivery of continence products: Yes □ No □

Client informed of repeat assessment and re-ordering of products: Yes □ No □

Check client understands information given: Yes □ No □

Assessed by: _____ Title: _____ Date: _____

Part 8: Forward assessment to relevant continence advisor /ADPHN
(see appendix VIII referral form for community continence advisory service)

Continence advisory service feedback:

Level 1 assessment received □ Date: ____ / ____ / _____

Bladder and Bowel record chart completed Yes □ No □

Recommendations: _____

_____

Products approved Yes □ No □ Details: _____

Home delivery to commence: Yes □ No □ Date of 1st home delivery ____ / ____ / _____

Signed: _____ Date: ____ / ____ / _____

Continence Advisor/ADPHN

Appendix VI - Bladder and bowel record chart

Instructions for completing bladder and bowel record chart

This chart helps your HCP assess how your bladder and bowel functions throughout the day so that he or she can accurately diagnose and treat your condition. Please complete the chart for 3 consecutive days and nights.

Fluid intake

How much did you drink?
Each time you have a drink, record the amount against the corresponding hour of the day or night. To do this measure the volume of your usual cup, glass or mug (in millilitres or fluid ounces) and estimate the fluid you drink by always using the same cup, glass or mug.

What did you drink?
In this column record what you drank, such as coffee, tea, water, beer.

Food intake

Please record foods that are rich in fibre, such as fruit, vegetables, breads and cereals.

Urine passed

How much urine did you pass?
In this column record the amount or volume of urine passed against the corresponding hour of the day or night. You will need to use a plastic measuring jug for this.

Did you have a strong sudden urge to go to the toilet?
In this column record if you experienced a strong and sudden urge to go to the toilet immediately, if it felt impossible to delay the need to pass urine.

Urine leakages

Did you have an accident and how severe was it?
If you were unable to make it to the toilet in time, causing urine to leak, record how severe the accident was by recording: D = damp, W = wet or V = very wet.

How much did you leak with cough/sneeze/exercise

Do you need to wear a pad or liner

How often do you change pad/liner in 24 hours

Bowel movements

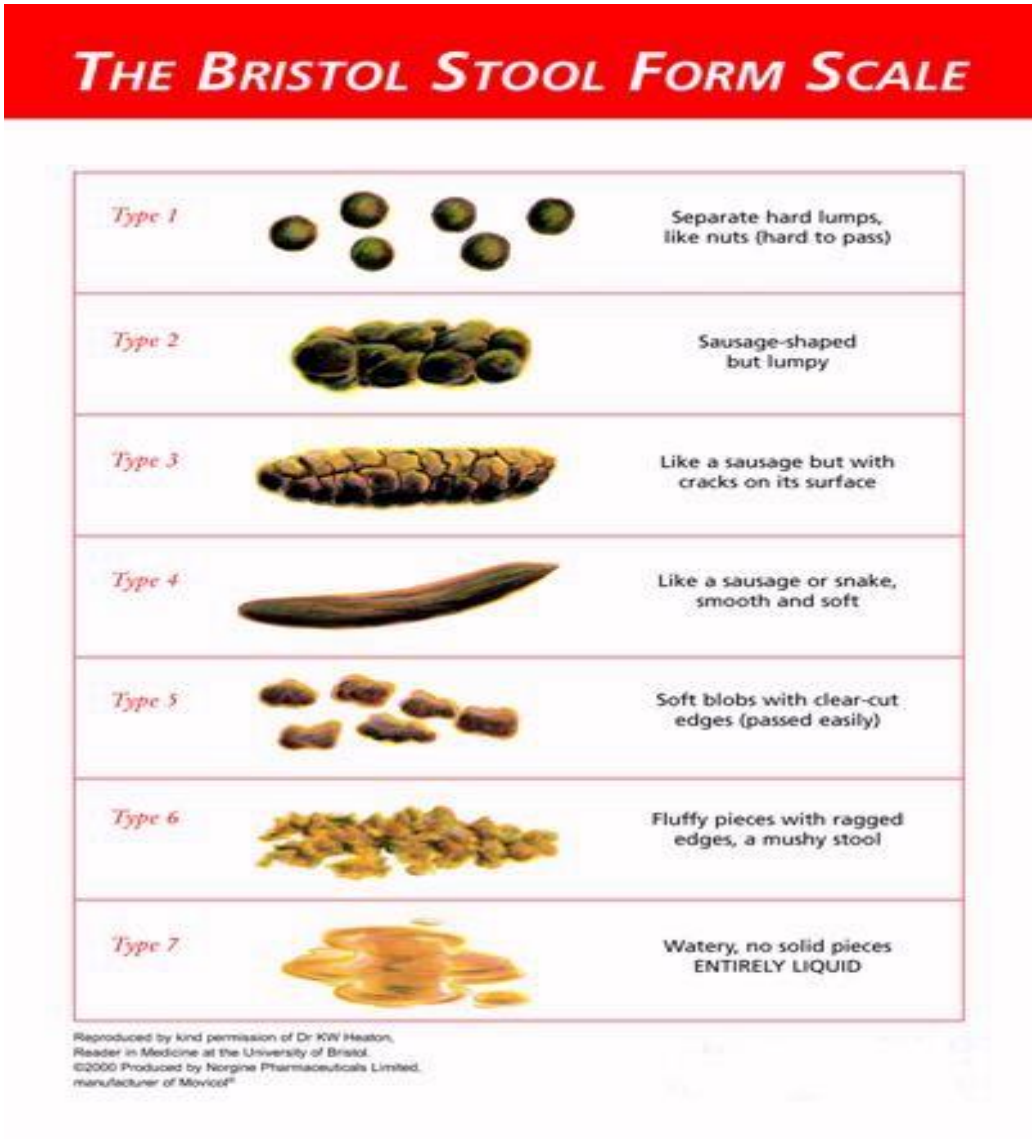
Did your bowels move?
Record yes against the relevant time if your bowels moved.

Did you soil yourself from your bowel?
If you soiled yourself or if you experienced any leakage from your bowel, record yes against the relevant time.

If you soiled when did it happen?

Bristol Stool Scale - record type (1-7, see over)

Please find attached the Bristol Stool Scale. Record which number best resembles your bowel movement and/or soiling episode.



Appendix VI Bladder and Bowel Record Chart (complete ONE PAGE FOR EACH DAY)

Time	**Day1:** Client name:_____ D.O.B:_____								
	Fluid intake		**Food intake fibre foods**	**Urine passed**		**Leakages**	**Bowel movements**		
	How much did you drink?	**What did you drink?**	**What did you eat?** e.g. fruit, veg, bread, cereals	**How much urine did you pass?**	**Did you have a strong sudden urge to go to the toilet?**	**If you had an accident how severe was it?** D = damp W = wet V = very wet	**Did your bowels move?** yes or no	**Did you soil yourself from your bowel?** yes or no When did it happen? on the way to toilet or after a motion	**Bristol stool scale** State which type 1-7
Example	200mls	tea	1 bowl porridge & 2 slices brown bread	100mls	no	W	yes	no	3
8am									
9am									
10am									
11am									
12noon									
1pm									

2pm									
3pm									
4pm									
5pm									
6pm									
7pm									
8pm									
9pm									
10pm									
11pm									
12MN									
1am									
2am									
3am									
4am									
5am									
6am									
7am									

Form completed by: _____ Date: _____

Appendix V11 Reassessment of Bladder and Bowel Function (Level 1)

Reassessment should be carried out when client's needs change, or following treatment interventions, or at least annually.

Name: _____D.O.B:_____I.D. no_____

Address:_____Eircode_____

Clients Phone No: _____Mobile:_____G.P_____

Client consents to data collection Yes □ No □ Continence

Contact Person:_____Phone No of Contact Person:_____

Previous Level 1 Baseline Continence Assessment Completed Yes □ No □

If No, do not complete this form. Please complete Level 1 Baseline Continence Assessment including 3 day bladder & bowel record charts.

Information Obtained From: Client □ Carer □ Nurse □ Other □_____

Information taken: Over phone □ In Person □ Client in Residential Care? Yes □ No □

Please document type of incontinence : urine □ faecal □ **Since Last Assessment/ Reassessment are there any changes to the following : (Please give details)**
Bladder function No □ Yes □
Bowel function No □ Yes □ Stoma No □ Yes □
Urinary catheter in situ since last assessment/reassessment No □Yes □
Changes in Medical /Surgical History No □ Yes □ **Urinalysis No □ Yes □** **Referred for Medical /GP Review No □ Yes □**
Skin Integrity No □ Yes □
Manual Dexterity / Functional ability No □ Yes □
Current Treatment Plan for promoting continence reassessed (Please give details) **Toileting program □ Toileting aids □** **Fluid intake □ Diet □** **Pelvic floor exercise □ Bladder retraining □** **Current Treatment plan still effective No □ Yes □ Give details of changes to treatment plan**

DETAILS OF CONTINENCE WEAR CURRENTLY SUPPLIED BY THE HSE

	Product Name	HSE CODE	AMOUNT
DAY			
NIGHT			
NET PANTS			

Are These Products Satisfactory for Clients Needs? Yes □ No □

If No; please state reason_____

_____

NEW ADJUSTED ORDER FOR CONTINENCE WEAR (only complete this part if a change is required)

	Product Name	HSE CODE	AMOUNT
DAY			
NIGHT			
Net Pants			

If a change in size of product is required please record abdominal Girth measurement_____cm's

Do you have any overstock of products? Yes □ No □ Details:_____

Are the address & delivery details the same? Yes □ No □ Details:_____

Completed by: _____ **Title: _____**

Health Centre/Residential Centre/ /Residential House/Nursing Home: _____

Telephone no:/Mobile No: _____ **Date _____**

Please forward to the relevant Coordinator/ Continence Advisory Service (as per local arrangements)

Repeat level 1 assessment received □ **Date**:

Appendix VIII HSE Referral Form for Community Continence Advisory Service (level 2)

(This form is designed to be completed electronically. For writing, please expand the boxes that need more details before printing and ensure all print is in capital letters and legible)

Adult Referral ☐ **Child Referral** ☐

Client Name:	**GMS/LTI No:**
Address: **Eircode:**	**DOB:** **Contact No:**
Contact person if different to above –Name, address and phone number:	
Does the client need to be accompanied to appointment? Yes ☐ No ☐	
Client's Next of Kin:	**Contact No:**
GP Name & Address:	**Contact No:**
Referrer's Name and Title (Print):	**Email:**
Signed (no signature required if emailed):	**Phone:**
Other Relevant Services involved (If child – Include Name of School)	
Relevant Obstetric/Surgical/Medical/Social History:	
Adult Urinary /Bowel Symptoms: *Please provide as much detail as possible (include with the referral any bladder/Bowel record charts and/or relevant reports)*	
Child Urinary /Bowel Symptoms: **Please tick if present**: Toilet trained ☐ Daytime wetting ☐Enuresis ☐ Constipation ☐ Faecal Soiling ☐ *Now please provide as much detail as possible (include with the referral any bladder/Bowel record charts and/or relevant reports)*	
Please describe the management plan already in place, including any treatment commenced or tried relating to this continence problem:	

Is the client in receipt of any continence products from the HSE? **Yes ☐ No ☐**	
Client aware of the referral Yes ☐No ☐	**Has the client consented to referral: Yes ☐No ☐**
FOR HSE OFFICE USE ONLY: **The referral is accepted ☐ Estimated date of client assessment: / / Or** **The referral is not proceeding for the following reasons:**	

Appendix VII - Audit Tool

1. Audit tool

Objective of audit tool:

Each statement in the audit tool is taken from the accompanying national procedure for the promotion of continence care and provision of products to clients. Each CHO area can assess to what degree they comply with the statements in their own area of approval and provision of such products. It is intended that this audit tool will provide each area with a baseline tool through which they can assess their own process and identify areas which require improvements.

Users of this audit tool can add additional statements as they deem appropriate, and adopt this tool for use in their own setting. Use the audit tool to retrospectively audit practices.

Methodology

Population	A sample of clients requiring bladder and bowel assessment and approval in the community of the provision of continence products
Sampling	A total of 10% or 10 clients, whichever is greater, should be selected
Frequency of audit	To be determined locally, but at least annually
Method	This is a retrospective audit

Part 1: Demographic details

CHO area:	
Work address:	
Area of practice (nursing, medical, etc)	
Date of audit:	
Audited by:	

Part 2: Data collection tool

Methodology: Record **Y** for **Yes**, if the criteria are met.

Record **N** for **No**, if criteria are not met or **N/A** for **not applicable**

Assessment of bladder & bowel	**Yes**	**No**	**NA**	**Evidence**
Statement 1 Documented assessment of bladder and bowel completed Statement 2 Evidence of urinalysis completed Statement 3 Where urinalysis is abnormal referred to GP Statement 4 Bladder and bowel chart completed for minimum of 3 days by client or carer Statement 5 Bladder and bowel record chart reviewed by RN Statement 6 Evidence of documented care-plan Statement 7 Evidence of care plan discussed and agreed with patient Statement 8 Evidence client commenced on appropriate conservative management Statement 9 Evidence of client referred onwards to relevant HSCP e.g referral to physiotherapist. Statement 10 Evidence of bladder and bowel assessment signed and dated by RN.				

Audit score: %				

Calculate audit score:

Calculate the score by dividing the number of 'yes' answers by the total of 'yes' and 'no' answers. Exclude 'not applicable' answers are excluded from the calculation of the percentage score.

The audit tool calculates the score for the audit. Example: If there are 5 'yes' and 5 'no' answers, the score is: 5 (yes answers) divided by 10 (total of yes and no answers) multiplied by 100. The score in this example would be 50%.

Provision of containment product	Yes	No	NA	Evidence
Statement 1 Documented assessment of bladder and bowel completed before issuing any products Statement 2 Evidence of interventions used to treat the cause of incontinence, such as fluid review, pelvic floor exercises and timed toileting Statement 3 Client assessed for suitability of products which preserve continence, such as hand-held urinal, raised toilet seat or commode Statement 4 Evidence of identification of appropriate products from contracted product list Statement 5 Evidence of continence order form completed Statement 6				

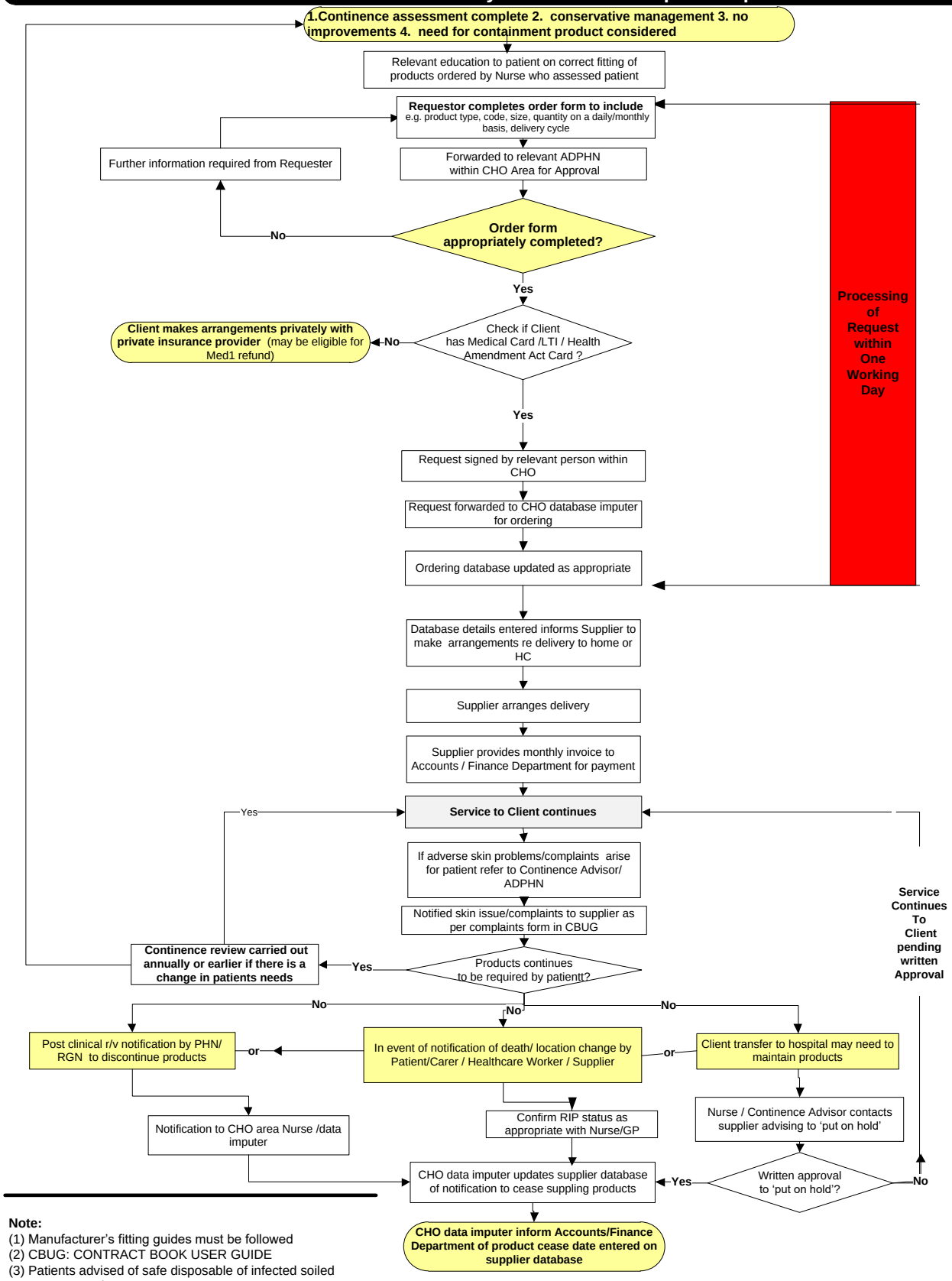
Satisfactory product ordered to meet needs (usually 1- 4 per 24 hours) Statement 7 Evidence of details of order supplied to CHO staff data inputter Statement 8 Client or carers provided with contact details for service, information on how to use products, reorder, and arrange a review Statement 9 Evidence of annual review of bladder and bowel health and product fit and effectiveness complete				
Audit score: %				

Calculate audit score:

Calculate the score by dividing the number of 'yes' answers by the total number of 'yes' and 'no' answers. Do not include 'not applicable' answers.

Example: If there are 5 "yes" and 2 "no" answers, the score is calculated as follows: 5 (yes answers) divided by 7 (total of yes and no answers) multiplied by 100. The score in this example would be 71%.

Process for Provision & Delivery of continence disposable products



Note:
(1) Manufacturer's fitting guides must be followed
(2) CBUG: CONTRACT BOOK USER GUIDE
(3) Patients advised of safe disposable of infected soiled products