NHS
Quality Improvement Scotland

Best Practice Statement ~ *November 2005*

Continence - adults with urinary dysfunction

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Introduction

NHS Quality Improvement Scotland (NHS QIS) was set up by the Scottish Parliament in 2003 to take the lead in improving the quality of care and treatment delivered by NHSScotland.

The purpose of NHS QIS is to improve the quality of healthcare in Scotland by setting standards and monitoring performance, and by providing NHS Scotland with advice, guidance and support on effective clinical practice and service improvements.

A series of best practice statements has been produced within the Practice Development Unit of NHS QIS, designed to offer guidance on best and achievable practice in a specific area of care. These statements reflect the current emphasis on delivering care that is patient-centred, cost-effective and fair. They reflect the commitment of NHS QIS to sharing local excellence at a national level.

Best practice statements are produced by a systematic process, outlined overleaf, and underpinned by a number of key principles:

- They are intended to guide practice and promote a consistent, cohesive and achievable approach to care. Their aims are realistic but challenging.

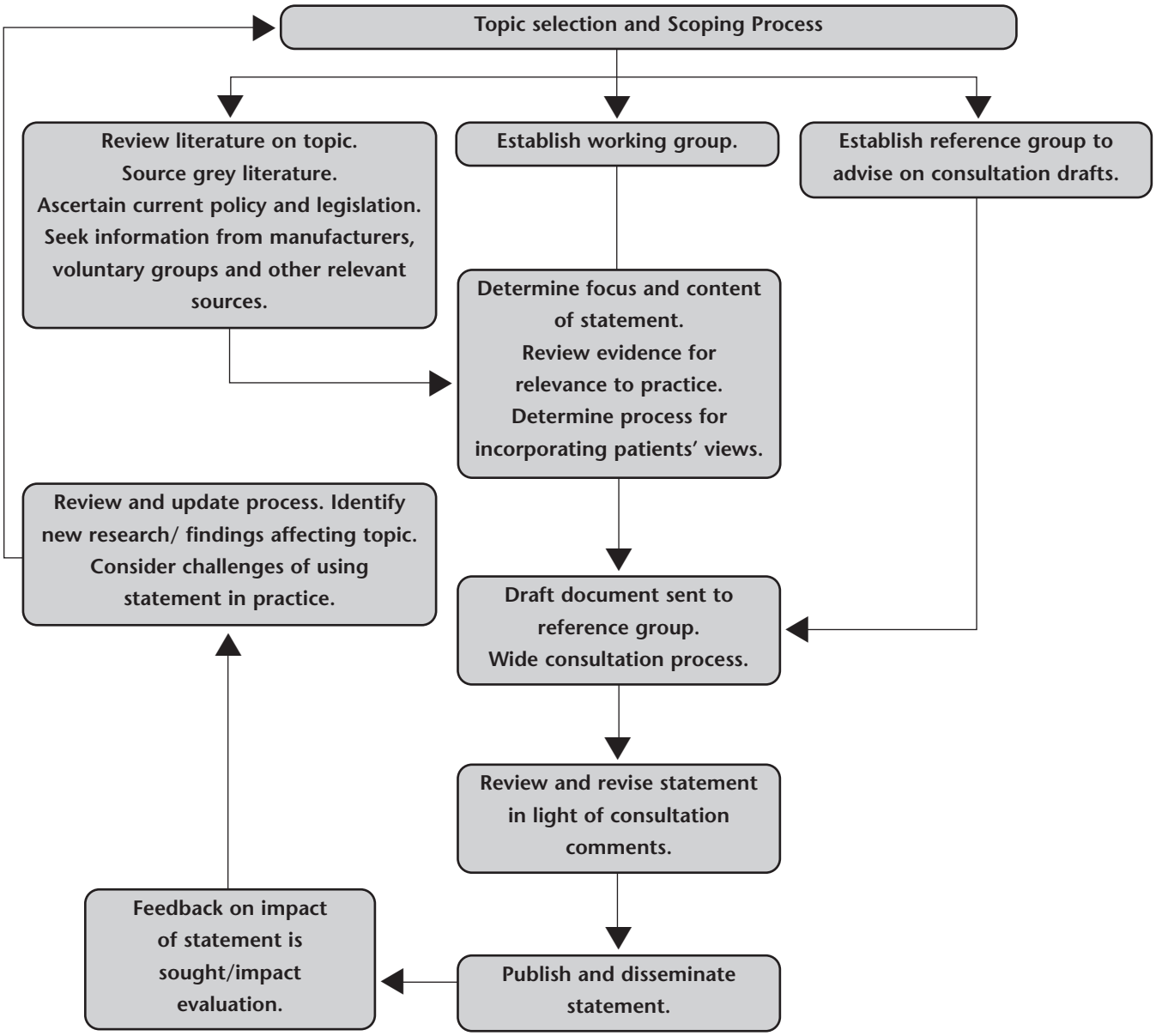
- They are primarily intended for use by registered nurses, midwives, allied health professionals, and the staff who support them.

- They are developed where variation in practice exists and seek to establish an agreed approach for practitioners.

- Responsibility for implementation of these statements rests at local level.

Best Practice Statements are reviewed, and, if necessary, updated after 3 years in order to ensure the statements continue to reflect current thinking with regard to best practice.

Key Stages in the development of best practice statements



Best Practice Statement on Continence - adults with urinary dysfunction

This best practice statement was originally produced by the Nursing and Midwifery Practice Development Unit to offer guidance to nurses, midwives and health visitors on best practice relating to the assessment of urinary dysfunction in the care of adults in primary and secondary care settings. A multidisciplinary working group was set up with professional representation from across Scotland. (Appendix 2). The statement was reviewed and updated in 2005. In addition to the review process, an audit tool has been developed to support practitioners/organisations wishing to audit their continence care.

Continence issues can affect people of all ages who come into contact with health services in both primary and secondary care settings. It is estimated that between 5 and 9% of the adult population in Scotland have significant problems with urinary continence (SIGN guideline 79). The Continence Foundation estimates that incontinence costs the NHS across the UK £423 million. Causes and contributing factors are many and varied. Incontinence can have a profound effect on an individual's quality of life. There may also be an impact on wider health issues, eg urge incontinence in older women has been associated with an increased risk of falls and fractures (Brown JS et al 2000). This best practice statement aims to provide practitioners with a framework which can be used when making decisions about the management of continence. A thorough and accurate assessment of individual continence status is essential in order to determine appropriate treatment.

The statement covers all care settings. It is recognised that where a patient does not have a holistic assessment undertaken (eg minor injuries unit) then the nurse should use clinical judgement concerning the relevance of urinary dysfunction.

A key element of the statement is that all patients should have access to appropriate toilet facilities. Concerns were raised about people in outpatient or GP clinics who would require assistance to access the toilet, although there were no comments about the consequences for the patients if they were denied access to toilets. The statement tries to reflect staff concerns without accepting the conclusion that patients who can not go to the toilet independently have two choices: to either avoid outpatient/GP appointments or to accept the potential humiliation of an incontinent episode.

The original consultation indicated that some areas would prefer to categorise patients at the outset as those who would benefit from continence promotion and those assigned to incontinence containment. The original working group considered that in all cases the initial aim should be the restoration of continence. This was confirmed by the subsequent review of the statement. It was accepted that, following comprehensive assessment, this goal may need to be revised. In all cases, however, a continence care plan should be implemented and evaluated.

Section 1: Promoting continence awareness

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
All staff are aware of the effect that their practice can have on a patient's continence status.	Each nurse/midwife will have concerns specific to their own area of expertise (eg attention to pelvic floor during pregnancy and delivery, initial care of orthopaedic patients, attention to toileting with confused or depressed patients).	All local procedure manuals include reference to continence difficulties, specific to the relevant speciality, which may be experienced by patients.
All staff are aware of the effect that personal habits can have on continence status, and support patients and public by providing accurate information to promote healthy practices.	People often restrict fluids believing this will reduce episodes of incontinence. Frequency and urgency of urination can be aggravated by people voiding frequently 'just in case' – ultimately reducing bladder capacity.	All displays of public information leaflets include general information on appropriate fluid intake and toileting habits, to promote the healthy bladder.
All staff are aware of the potential for improvement in quality of life that can be achieved by patients with appropriate continence care, and of the low expectations from continence care which patients tend to have.	"Selected patients in the community have shown a 70-80% cure or improvement rate" (Royal College of Physicians 1995). District nurses cited low patient expectation as one of the main barriers to implementing an effective continence management plan.	All nurse/midwife training initiatives relating to continence include information on the potential for improvement.

Section 2: Access to toileting facilities

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
All patients, at every stage of their patient experience, have access to appropriate toileting facilities.	All patients have the right to strive to maintain/achieve continence. Containment/catheterisation should not be used for 'convenience' alone.	Accessible toilet facilities are provided within all patient areas of health service premises.
		Patients are able to contact staff to assist them with toileting as required.*
		Patients in their own homes benefit from supply of equipment to facilitate toileting as required.
		Patients in residential care settings have evidence of individual toileting requirements documented in their care plan.

* *In certain settings (such as health centres) patients who need moving and handling equipment to transfer will normally have established coping strategies. Where a patient requires assistance to toilet beyond those facilities available in health centres or out-patient areas, alternative consultation options should be offered.*

Section 3: Assessment of urinary dysfunction

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
*Initial assessment of all patients undergoing a holistic nursing assessment, includes questions regarding bladder function/habit.	Urinary incontinence is a common problem affecting up to 10% of the population (Roe et al 1996). 3.8% of people over 40 both experience symptoms of urinary problems and want help (Perry 2000).	Records of all holistic nursing assessments include reference to continence status, and any current treatment. The initial assessment of a patient's continence status, in addition to general information gathered, includes the items listed in Figure 1,p.4.
**Where symptoms of urinary dysfunction are identified the patient has a comprehensive continence assessment.	"Urinary incontinence is a symptom not a diagnosis….. assessment is of crucial importance as effective management is determined by accurate diagnosis of the type of incontinence" (Cheater et al 1999 p2).	All nurses have access to information on assessing incontinence and associated continence care planning. All nurses have access to an assessment tool.
The assessment is transferable across care settings and remains with the patient throughout their health care experience.	The embarrassment felt by patients, in discussing their continence needs, is minimised by new professional contacts already having the information available. Patients recognise there is insufficient liaison between professionals (ACA 2000).	There is evidence of a discharge arrangement to forward continence assessments/care plans throughout the patient's care.
Continence assessment is clearly distinguished from absorbent product orders.	It is recognised that continence 'assessments' at present are often little more than an order form for absorbent garments (Audit Commission 1999).	Continence assessment tools include information relating to diagnosing the cause of incontinence, and care planning.

* *Whilst it is recognised that there are situations where it may be inappropriate to ask questions regarding toileting difficulties eg in a travel vaccination clinic, it must also be remembered that people of all ages and abilities can have continence problems. The traveller may suffer from nocturnal enuresis and dread episodes away from home.*

** *It is appropriate for assessment to be undertaken by students in their pre-registration consolidation placement and by all levels of registered staff. Health Care Assistants may contribute to the ongoing process of continence assessment through gathering of information and providing feedback. Physiotherapists and Occupational therapists with additional expertise in the area may undertake continence assessment in accordance with their professional guidelines.*

Table 1: Initial assessment of urinary dysfunction

(This table represents a consensus of the working group. It was developed by comparison of continence assessment tools submitted from across Scotland.)

Topic	Focus for Questioning / Investigation
Main complaint	Gives a general impression of the patient's view of what needs to be resolved
Incontinent episodes	Volume, frequency and timing – use chart for clear picture
Toilet Pattern Capacity	Patient may be continent but only due to excessively frequent toileting ➜ reduced bladder
Effect on quality of life	Increased laundry, reduced social activities, employment, intimacy
Onset of problem	May be indicative of cause/type of incontinence
Patient expectations	Patient participation greatly improved if aiming for common goals
Previous assessment/treatment	What worked? What didn't? Why?
Environmental influences	Barriers to toileting: seating, distance, stairs, doors, staff/carer availability
Mobility/dexterity	Particularly with reference to dressing, undressing and toileting
Urinary symptoms	Such as: frequency, urgency, dysuria, volume of leakage and voiding difficulties
Fluid intake/output	Too little ➜ concentrated urine ➜ irritated bladder; too much ➜ bladder compliance problems
Diet	Effects on bowel habit/urinary pH
Condition of skin	Problems due to incontinence/inappropriate containment
Urinalysis	Symptomatic UTI, diabetes, concentrated urine, pH, microscopic haematuria, proteinuria
Medication	Review for side effects, as well as continence treatment
Medical/surgical history	Particularly with reference to pelvic, abdominal, spinal and neurological problems
Smoking	Chronic cough/peripheral neuropathy/bladder cancer

Topic	Focus for Questioning / Investigation
Obstetric history	Possibility of pelvic floor damage, dyspareunia
Menopausal status	Falling oestrogen levels ➜ dry vagina/urethral mucosa
Mental health	Awareness/effect on self care and self esteem
Behavioural difficulties	Manipulation using toileting behaviour, wetting or soiling
Patient's coping strategy	Alternatives to toilet (such as excessive frequent toileting/containment) used
Bowel Habit	History of straining, constipation or faecal impaction
Faecal incontinence	Patient may be reluctant to mention faecal problems despite discussing urinary incontinence

Section 4. Continence Care Planning

Statement	Reasons for Statement	How to Demonstrate Statement is Being Achieved
The nurse analyses the information gathered and using clinical judgement, formulates a diagnosis and develops a care plan. The aim is restoration of continence.	Clinical governance means not only conforming to treatment standards, but also ensuring that treatment is offered to anyone for whom it would be beneficial (Continence Foundation 2000).	Following a comprehensive continence assessment the patient's nursing notes show evidence of continence care planning.
Continence management plans are developed that are relevant to the type of incontinence identified.	There is considerable evidence that individualised management plans can restore continence or greatly improve the quality of life for patients living with incontinence (Button et al 1998).	All nurses have access to information on the types and causes of incontinence and the relevant management strategies. (Figure 2, p.6 provides preliminary information). All nurses have the opportunity to regularly update their knowledge.
The effect of the continence management plan is evaluated at regular intervals.	Assessment and care planning does not guarantee improvement. The patient's progress must always be monitored. A patient's health will change in relation to many factors and this change may impact on continence status requiring a new assessment and management plan.	All areas which provide ongoing care for patients have an arrangement to undertake regular reviews of continence status and continence management plans. Patients who are receiving continence care are regularly reviewed to detect and address changes in their condition. Following review the patient's management plan is amended as appropriate.

Table 2: Basic guidance for continence care planning

The following pages have been adapted from the Continence Foundation "continence management" wheel (1992), available in the Continence Foundation's "Continence Resource Pack". These tables provide basic information to link data gathered at initial assessment with the management options available to nurses. Further reading is included at the end of the section.

2a. Functional Incontinence

Signs/Symptoms	Unable/unwilling to use toilet
Trigger questions (observation of patient essential)	Do you have difficulty getting to the toilet? Do you know how to call for help (if required) to take you to the toilet? Observe patient accessing toilet, **ensure** they can undress, sit on toilet, and redress. Essential on home visits/prior to discharge
Underlying Cause	Reduced mobility/dexterity Unavailable/unwilling carers Confusion/disorientation Lack of motivation/depression Communication difficulties
Control affected by	Attitude/availability of carers Dehydration Polypharmacy Sedation Diuretics Anti-depressants
Check for:	Ability to use toilet Dehydration Faecal impaction/constipation
Nursing management	Optimise environment Signpost toilet facilities Rehydrate Clear faecal impaction/normalise bowel habit Implement individualised toileting regime/bladder retraining programme Motivate both patient and carers

Signs/Symptoms	Unable/unwilling to use toilet
Team discussion	Staff attitudes Review medication Occupational therapy/Physiotherapy input
Onward referral	Psychiatric assessment as appropriate

2b. Stress urinary incontinence

Signs/Symptoms	Small spurt of urinary leakage with exertion generally leading to damp underwear
Trigger questions (positive response indicative of stress incontinence)	Do you leak when you cough/sneeze/lift? Do you leak if you run eg for a bus? Do you leak if you walk downhill? Do you leak when you rise from a chair? Do you leak without feeling the need to empty your bladder? When you leak do you wet your underwear only?
Underlying Cause	Incompetent urethral sphincter Weak pelvic floor muscles
Control affected by	High fluid intake Chronic cough (+/-smoking) Heavy lifting (e.g. at work) Athletic lifestyle (hurdling/trampoline) Pregnancy Constipation Reduced oestrogen production (pre-menstrual/post-menopausal)
Check for:	Appropriate fluid intake/voiding pattern Constipation Vaginal prolapse Atrophic changes
Nursing management	Normalise fluid intake/toilet pattern Advise re smoking Normalise bowel habit
Team Discussion	Treat cough Pelvic floor exercises +/- medication as appropriate Post menopausal vaginal symptoms
Onward referral	Specialist physiotherapy assessment and advice re pelvic floor re-education Urological/gynaecological opinion

2c. Urge incontinence

Signs/Symptoms	Uncontrollable urgent desire to void, often results in wet clothing
Trigger questions (positive response indicative of urge incontinence)	Do you feel that you are suddenly desperate for the toilet and unable to hold on? Does your bladder start to empty when you put the key in the door/reach the toilet? Do you feel your bladder emptying? When you leak are your clothes wet?
Underlying Cause	Overactive bladder – bladder contracts during filling phase
Control affected by	Caffeine intake Low fluid intake Diuretic medication Urinary tract infection Reduced mobility/dexterity Anxiety
Check for:	Urinary tract infection Constipation Neurological disease Post void residual urine Diabetes mellitus
Nursing management	Normalise fluid intake Treat urinary tract infection Normalise bowel habit Individualised toileting programme/bladder retraining Reduce caffeine intake if appropriate
Team discussion	Anti-muscarinic therapy – unless large post-void residual (significant>150mls) Pelvic floor exercises Post menopausal vaginal symptoms
Onward referral	Specialist physiotherapy assessment and advice Urological assessment

2d. Mixed urge and stress incontinence

Signs/Symptoms	Combination of small spurt urinary leakage on exertion and whole bladder emptying associated with urgency
Trigger questions	As for stress and urge but giving a mixture of positive responses
Underlying Cause	Overactive bladder and incompetent urethral sphincter/weak pelvic floor muscles
Control affected by	Caffeine intake Low/high fluid intake Urinary tract infection Anxiety Obesity Chronic cough Low oestrogen levels (pre-menstrual/ post-menopausal)
Check for:	Appropriate fluid intake/voiding pattern Urinary tract infection Constipation Vaginal prolapse Atrophic changes Neurological disease Diabetes mellitus
Nursing management	Reduce caffeine intake Normalise fluid intake Treat UTI Normalise bowel habit Individualised toileting programme/bladder retraining Advise re weight loss/smoking
Team discussion	Anti-muscarinic therapy - unless large post-void residual (significant>150mls) Pelvic floor exercises Treat cough Post menopausal vaginal symptoms
Onward referral	Specialist physiotherapy assessment and advice Urodynamic assessment where: • first line measures have not resolved the problem • surgical intervention is being considered

2e. Incomplete bladder emptying

Signs/Symptoms	Hesitancy, poor stream, passive dribble, frequency, urgency, nocturia, nocturnal enuresis, feeling of incomplete emptying. Recurrent UTI
Trigger questions (positive response indicative of overflow incontinence)	When you have passed urine do you feel there is still more to pass? Do you have difficulty starting to pass urine? Do you have to strain to pass urine? Do you have to return to the toilet minutes after having passed urine?
Underlying Cause	Outflow obstruction eg enlarged prostate Underactive bladder muscle Bladder muscle contraction and urethral sphincter relaxation not co-ordinating during voiding
Control affected by	Anti-muscarinic medication can increase retention by relaxing the bladder muscle
Check for:	UTI Post-void residual urine (significant>150mls) Faecal impaction/constipation Neurological disease History of prostatic enlargement Dribbling due to pooling of urine in male urethra Vaginal prolapse
Nursing management	Treat symptomatic UTI Clear faecal impaction/normalise bowel habit Allow peace and privacy to void Educate re correct voiding position Male – manual urethral emptying post-void if pooling of urine Intermittent self-catheterisation
Team discussion	Prostate assessment ➜ medication Neurological assessment Urological assessment
Onward referral	Urological assessment Neurological assessment

2f. Reflex incontinence

Signs/Symptoms	No sensation/awareness of bladder filling/emptying
Trigger questions (Due to the nature of their condition patients with reflex incontinence may be unable to respond to questioning. However this does not mean that all patients who are unable to respond have reflex incontinence)	Are you aware of bladder sensation?
Underlying Cause	Nervous system unable to relay impulses from bladder to brain for interpretation and appropriate response. Bladder empties under control of spinal reflex, without the brain's influence Spinal/brain injury/tumour Disease of the nervous system Underdevelopment of the nervous system
Control affected by	There is no ability to control bladder function
Check for:	History of disease of nervous system
Nursing management	Establish pattern of fluid intake ➜ reflex void Individualised timed toileting Measures to trigger sacral reflex eg tapping bladder, stroking inner thigh Intermittent catheterisation may be appropriate Containment with planned changes appropriate to reflex pattern
Team discussion	Establish with patient/carer/team the most acceptable way of achieving 'social continence'
Onward referral	Neurological assessment as appropriate

2g. Nocturnal enuresis (can also be a symptom of bladder overactivity or incomplete bladder emptying)

Signs/Symptoms	Unknowingly passes urine while sleeping
Trigger questions (negative response indicative of nocturnal enuresis)	Are you aware of the need to void before you wet the bed? Do you wake before you wet the bed?
Underlying Cause	Inability to concentrate urine Reduced bladder capacity Reduced bladder sensation Reduced motivation.
Control affected by	Cardiac failure/oedema Anxiety/stress Diurnal variation in old age Sedation Fluid/caffeine intake Alcohol
Check for:	Symptomatic UTI Has night-time continence ever been achieved? Medication (possible effects on bladder function)
Nursing management	Treat symptomatic UTI Normalise fluid intake/review alcohol intake Improve motivation Look at underlying cause
Team discussion	Review patient's case history Review side effects of current medication Behavioural therapy Enuresis alarm Drug therapy
Onward referral	Enuresis clinic Urological assessment

Glossary

anti-muscarinic	medication which reduces bladder spasm
assessment	a thorough review of the patient's condition, by questioning, observation and physical examination
constipation	emptying the bowels less frequently than the patient's normal habit
containment	means of preventing urinary leakage onto clothing/furniture
continence	being able to control the passing of urine
diuretic	medication which increases urine production
dysfunction	not working properly
dyspareunia	pain during sexual intercourse
dysuria	pain on passing urine
faecal impaction	solid faecal matter blocking the bowel
functional incontinence	wetting due to being unable or unwilling to access a toilet
gynaecological	related to health of women's reproductive system
haematuria	blood in the urine
management plan	a description of the patient's future treatment
nocturia	passing urine at night
nocturnal enuresis	uncontrolled passing of urine at night
oestrogen	a female hormone
pelvic floor	the sling of muscles which supports the bladder
peripheral neuropathy	disease of the nerves outwith the spine and brain
polypharmacy	multiple medicines
post-void residual	volume of urine left in the bladder immediately following bladder emptying
proteinuria	protein in the urine
reflex incontinence	passage of urine as a result of completion of spinal reflex arc, outwith brain control
stress incontinence	leakage of urine, on exertion, due to weak pelvic floor
toilet habit	usual individual routine for emptying bladder/bowel.
toileting requirements	assistance or equipment required to facilitate emptying of bladder/bowel.
urethral sphincter	small circular muscle around the entrance to the bladder which tightens to hold urine in and relaxes to allow passage of urine

urge incontinence	leakage of urine, due to uncontrollable bladder spasm
urinalysis	testing of urine specimen with a 'dipstick' - for sugar, protein etc.
urinary tract infection	infection of bladder, ureters or kidneys
urogynaecological	related to health of women's urinary and reproductive systems
voiding	passing urine

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Recommended reading:

Button, D. Roe, B. Webb, C. Frith, T. Colin-Thome, D. Gardner, L. (1998). *Continence: promotion and management by the primary health care team*. London: Whurr.

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Appendix 1

Best practice statement audit tool
Continence care –
adults with urinary dysfunction

NHS
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This audit tool is also available at www.nhshealthquality.org

In some sections the audit tool provides lists of data to be recorded. Best practice suggests 100% of information should be recorded. It is for each user to agree what percentage would count as meeting the criteria.

This audit tool is intended to be used as part of the audit cycle. This can be described as the use of audit to identify areas for improvement, drawing up a plan and implementing improvements in these areas, and re-auditing to evaluate and define areas for further improvement. This should raise the standard expected with each cycle of audit.

This tool may be used by organisations to audit their continence service or adapted by individuals to audit their own practice.

Best practice statement audit tool **Date of audit** .....

Continence care **Name of auditor** .....

Criteria to be audited	Yes	No	Action
Do local procedure manuals include reference to continence difficulties, specific to your speciality, which may be experienced by patients?			
Is continence training provided for staff?			
What % of nursing/care staff have attended continence care training in the previous 12 months?			
Do all displays of public information leaflets include general information on appropriate fluid intake and toileting habits, to promote the healthy bladder?			
Are accessible toilet facilities provided within all patient areas of your service premises?			
Are patients able to contact staff to assist them with toileting as required?			
Does your service use a continence assessment tool?			
Is the patient's continence care plan transferred through all care areas?			
	No of records audited	No meeting criteria	% meeting criteria
Do **all** patients have evidence of individual toileting requirements documented in their care plan (to enable continence)?			
Do all individuals with continence problems have a personal continence care plan taking into account: • individual's perception of problem/solution • individual's own coping strategies • environmental influences • mental health • fluid intake • urinalysis • frequency/volume of incontinent episodes • condition of skin • diet/bowel habit • medication effects/side effects • previous assessments/treatments Is consideration given to any other risk factors eg: • reduced mobility/dexterity • infection control issues • moving and handling issues • acute illness			
For individuals for whom continence problems have been identified, is there evidence within the personal continence care plan of a proactive approach to regain continence rather than containment (pads/sheaths/catheters) as the sole solution?			
For individuals who have a continence care plan is there evidence of the plan being evaluated and revised as appropriate?			

Appendix 2

Who was involved in developing and reviewing the statement?

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Statement review 2005

The reference group provided consultation to the original document developed by the working group, and it was then sent out for wider consultation across Scotland. The statement was reviewed by reconvening members from the original working group. Those marked * took part in the review process, updating the statement and by further consultation with relevant specialists across Scotland.

Support from NHS QIS

Penny Bond Practice Development Professional Officer
Rosemary Hector Practice Development Project Co-ordinator

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