Good practice in continence services


Summary
The Department of Health, England, issued new guidance on continence services earlier this year. Sue Thomas examines the guidelines with a view to the future of continence care.

Introduction
Just before Easter this year, the Department of Health issued new policy guidance on continence services (DoH 2000). Good Practice in Continence Services will, at last, make the subject of continence every nurse’s business.

The national review of continence services was chaired by Professor Paul Abrams, of the Bristol Urological Institute, and conducted by an expert group that included two nurses representing the Royal College of Nursing: Angela Billington, a continence nurse specialist from Yeovil, Somerset, and former chair of RCN continence care forum, and Christine Norton, a continence nurse specialist at St Mark’s Hospital, London.

The guidance was developed as the result of a long lobbying campaign initiated because of inadequacies in service provision, which were made worse by the re-imposition of VAT on continence products.

The guide was launched to nurse executive directors in NHS trusts, health authority medical advisers, medical directors of NHS trusts and nurse advisers in local health authorities and primary care groups with a joint letter from the chief medical officer, Professor Liam Donaldson and chief nursing officer for England, Sarah Mullally.

As is the case with most other policies, it is also available to everyone and can be downloaded from the internet. The website address is: www.doh.gov.uk/continenceservices.htm. This means that all nurses can become involved in ensuring that these guidelines are implemented.

Comprehensive continence services – an integrated service
The Department of Health’s new guidance now outlines a vision for integrated continence services for the future and states that continence services: ‘...should be based upon and evolve from’ existing local continence advisory services. The onus is now on all healthcare providers to commission integrated services under a director who: ‘...would usually be a specialist continence nurse or physiotherapist.’

It says continence services will be cohesive and comprehensive. Services will extend to faecal, as well as urinary, incontinence, to children as well as adults and to people living at home, in hospital or in long-term care.

The services will cover prevention, as well as treatment and management, of incontinence, with the heaviest responsibility for delivering appropriate continence services placed on primary care teams. However, nurses, health visitors and midwives, wherever they work, will now need to ‘think continence’ when treating patients.

Patient groups for whom continence might previously have been low on the care agenda are mentioned specifically. These include:

- People with long-term physical disabilities, neurological conditions and learning disabilities.
- Prisoners, asylum seekers and refugees.
- Homeless people and those living in hostels.
- Older people in residential and nursing homes.
- Ethnic minority groups.
- Children in foster care and at boarding schools.
- Travelling people.

New director post
The guidance proposes creating a director of continence services post. This post is likely to be filled by a continence nurse specialist or physiotherapist, who will take the lead in developing shared policies, protocols and pathways that will make for a cohesive and comprehensive service.

The guidance outlines three levels within the integrated service so that, organisationally, continence services will include:

- All those involved in the prevention of incontinence and the identification, assessment and treatment of people with incontinence (hospital nurses, primary care and community staff and staff in nursing and residential homes).
- Those providing a local specialist service: the...
director of the service, continence nurse specialists, paediatric nurses, physiotherapists and hospital-based specialists and services.

- Regional and national specialist surgical units.

The continence services director will bring together, lead and co-ordinate all staff in primary, secondary and tertiary care with outside agencies (social services, education authorities, care home providers, users and carers) to develop, agree and put into practice evidence-based policies, procedures and guidelines for continence care.

This practice will be subject to audit and review and will overcome the problem that different bodies employ various professionals providing care at different levels. The guidance recognises the need not just for better training of staff, but also for raising their awareness of the subject if nurses are to carry the responsibilities now given to them.

What does this mean for nurses?
The new guidance suggests a number of targets specific to the workplace, which healthcare providers should aim to meet. These include targets for:

- Health authorities, primary care groups and primary care trusts.
- Health authorities and children.
- Residential care and nursing homes.
- Inpatient care.

The guidance outlines continence actions, which can be implemented at a minimum cost, but for maximum gain. These have been highlighted in the chief medical officer (CMO) and chief nursing officer (CNO) letter with encouragement for early action and implementation (a copy of the letter can be downloaded from the website: www.doh.gov.uk/cmo/cmo0002.htm). The emphasis is on:

- Identification.
- Assessment.
- Treatment.
- Review.

### Identification
The guidance calls for ‘proactive identification’ of people with continence problems. It also emphasises the need to help carers understand incontinence and treatment, because incontinence is often the final straw for some carers in supporting patients at home.

### Assessment and treatment
Nurses will have to undertake a comprehensive assessment of each patient to elicit the cause of his or her incontinence. The guidance recommends a change of attitude by many nurses because containment, which, for many, has been the first line of treatment, is no longer acceptable without a management plan to address the cause of the incontinence.

Although patients who present with incontinence might currently be assessed, it is unlikely that many would previously have been discharged with comprehensive management plans that follow an agreed care pathway, even though there might be a simple solution to their incontinence.

The guidance suggests the following systematic approach to continence management:

- Individual staff identified and trained in continence assessment and management and allocated protected continence time as part of their jobs.

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<tr>
<th>Box 1. Ten-point assessment plan</th>
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<tr>
<td>1. Review of symptoms and their effect on quality of life</td>
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<td>2. Assessment of desire to receive treatment and alternatives</td>
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<td>3. Examination of abdomen for palpable mass or bladder retention</td>
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<td>4. Examination of perineum to identify prolapse and excoriation and assess pelvic floor contraction</td>
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<td>5. Rectal examination (not in children) to exclude faecal impaction</td>
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<td>6. Urinalysis to exclude infection</td>
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<td>7. Assessment of manual dexterity</td>
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<td>8. Assessment of environment, such as accessibility to toilet facilities</td>
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<td>9. Use of an activities of daily living diary</td>
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<td>10. Identification of conditions that might exacerbate incontinence, such as chronic cough</td>
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<tr>
<th>Box 2. Ten-point treatment plan</th>
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<td>1. Advice to patients on healthy living, especially diet and drinking appropriate fluids</td>
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<td>2. Bladder and bowel training regimes</td>
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<td>3. Bladder training/timed voiding prompted voiding for urge incontinence</td>
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<td>4. Improving quality and access to toilet facilities and improving mobility</td>
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<td>5. Pelvic floor exercises, particularly for women, to prevent or cure incontinence, and for patients with urge incontinence and older men with post-prostatectomy problems</td>
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<tr>
<td>6. Pelvic floor and anal sphincter exercises to improve faecal continence</td>
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<td>7. Provision of pads or continence aids, such as enuresis alarms or urinals</td>
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<td>8. Review of existing medication</td>
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<tr>
<td>9. Management of faecal impaction</td>
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<td>10. Medication</td>
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Proactive questioning carried out, particularly with children, pregnant women, new mothers, menopausal women, older people, carers and people with disabilities.

Assessment to encompass a ten-point assessment plan (Box 1).

Discussion and agreement of a personal plan for treatment and management of the condition with each patient.

Delivery of initial treatments from a ten-point treatment plan (Box 2).

Periodic review with referral – to specialists if necessary, in accordance with care pathways agreed with local continence services director.

Detailed record keeping.

Regular review and audit of services provided.

Continent products

Containment of incontinence is no longer acceptable and the guidance states that the supply of continence pads should be governed only by clinical need. It elaborates on these in a detailed annex, which also covers the use of washable products.

Audit

Audit and performance monitoring are built into continence services outlined in the guidance and additional performance indicators are recommended in many settings.

For example, it is suggested that nurses working in acute hospital wards should be assessed on their assessment and treatment of newly diagnosed patients using the ten-point assessment and treatment plans outlined.

The guidance states that the results of audit and performance should be available to other parties, such as researchers and voluntary organisations.

The way forward

The gauntlet has been thrown down and the new guidance means that all nurses should now proactively identify all those people in their care who have a problem with continence. This means undertaking a full assessment of the patient’s condition, delivering initial treatment and following up with a review, which can lead to reference to a continence specialist, and/or advanced diagnostics.

We have an excellent starting point with Good Practice in Continence Services and it now remains for nurses to press at local level for this guidance to be implemented. Nurses cannot do all that is needed, but they can be a potent force for change. Regardless of where they are working, nurses can ensure that every patient they see gets an appropriate continence assessment and care.

REFERENCES


FURTHER READING


Further information

The RCN continence care forum annual conference, Continence: Everyone’s Business, to be held on November 22-23 2000, will look at the new guidance. Free papers are particularly invited from nurses who have an interest in continence care.

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