Continence Care Policy

Policy information

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Summary of document:
This policy provides healthcare professionals with current evidence-based practice and guidance to support accountable care in relation to continence and bladder and bowel dysfunction.

Scope:
To promote high quality continence care to individuals who have bladder and /or bowel dysfunction. It provides guidance on promoting continence care and managing individual's continence needs.
This policy is intended to support all employees within Hywel Dda University.
Health Board involved in any aspect of continence care. This includes locum, bank or agency staff and any members of staff undergoing training e.g., pre-registration student nurses and midwives. The policy is provided as a reference source for all healthcare professionals.

To be read in conjunction with:
008 - Consent to Examination or Treatment Policy (opens in new tab)
811 - Mental Capacity Act Practice Guideline (opens in new tab)
289 - Record Keeping for Nurses and Midwives Policy (opens in new tab)
312 - Chaperone Procedure (opens in new tab)
037 - Tissue Viability and Wound Management Guideline (opens in new tab)
268 - Medicines Policy (Acute, Mental Health, Learning Disabilities and Community Services) (opens in new tab)
151 - Personal Protective Equipment PPE Policy (opens in new tab)

Patient information:
Include links to Patient Information Library

Owning group:
Bladder, Bowel and pelvic health forum
Date signed off: July 2022

Executive Director job title:
Mandy Rayani – Director of Nursing, Quality and Patient Experience

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1.0 – New Policy – 03.10.2011
2.0 – Revised 2017 – 11.04.2018
3.0 – Revised 11.11.2022

Keywords
Continence, Care, Assessment, Promotion, Bladder, Bowel, Dysfunction

Glossary of terms
HDUHB - Hywel Dda University Health Board
AWCF - All Wales Continence Forum
BPH - Benign Prostatic Hyperplasia
CNS – Clinical Nurse Specialist
BPS – Bladder Pain Syndrome
IC – Interstitial Cystitis (IC)
NMES - Neuromuscular Electrical Stimulation
MS - Multiple Sclerosis

OASI - Obstetric Anal Sphincter Injuries
HDS - Home Delivery Services
NHS – National Health Service
IAD - Incontinence Associated Dermatitis
WPCF - Wales Palliative Care Forum

Terms/definitions

Anticholinergic Medication

Also known as antimuscarinics, this group of medication is used to treat detrusor instability /overactive bladder by blocking muscarinic receptors at the detrusor, thus reducing bladder contractility. However, due to the muscle-relaxing properties and side-effects of constipation this can contribute to urinary retention. Adverse effects may include dry mouth, dry eyes, blurred vision, constipation and nausea. There is also an increased risk of impaired cognition and falls in patients over the age of 65 years. Immediate release oxybutynin should not be offered to older women who are at higher risk of a sudden deterioration in their physical or mental health. (NICE NG123)

Assessment

The assessment process offers an opportunity to explore the individual's wider needs e.g. continence and identify what action must be taken to meet them

Bladder Retraining

Bladder retraining is an education program that teaches the person to restore a normal pattern of voiding by setting scheduled voiding to achieve longer time intervals between voiding.

Continence

The ability to exercise voluntary control over the urge to urinate until an appropriate time and place can be found. The ability to control involuntary leakage of urine or faeces

Containment product

Washables, absorbent disposable products, nappies, toileting aids including hand-held urinals

Constipation

Bowel movements which are infrequent or hard to pass. Simple changes to your diet and lifestyle can often help treat constipation

Constipation with Overflow

Constipation followed by diarrhoea/loose stool is often caused because the passage of stools along the intestinal tract is being blocked by a hard mass of faeces usually in the back passage. This causes the more liquid feces behind to overflow or bypass the blockage and appear as diarrhoea.

Diarrhoea

Frequent episodes of loose or watery stools, typically a symptom of an underlying condition. This is not to be confused with 'constipation with overflow'

Detrusor

The detrusor muscle is a smooth muscle found in the wall of the bladder; this muscle remains relaxed to allow the bladder to store urine and contracts to release urine

Diuretic
An agent that promotes the excretion of urine. Diuretics decrease blood volume by enhancing salt and water excretion by the kidney and lowering the resistance of blood vessels, thereby lowering blood pressure. Diuretics can cause reversible UI by increasing frequency and urgency of urination

Dysuria
Abnormal discomfort or pain and a burning or smarting sensation accompanying voiding

Indwelling catheter
Also referred to as a “Foley”, an indwelling urinary catheter has a retention balloon, it can be inserted through the urethra or suprapubically to allow for bladder drainage. This catheter can be connected to a drainage bag to allow free drainage or can be used with a catheter valve to enable intermittent drainage of the bladder.

All staff are required to comply with the Health Boards policies and procedures and apply best practice in order to prevent Fraud, Bribery and Corruption. Staff should be made aware of their own responsibilities in protecting the Health Board from these crimes.
All staff have a duty to notify the Local Counter Fraud Department of any suspected fraud or inappropriate actions and are protected by the AW Raising Concerns (Whistleblowing) Policy. Anyone who suspects fraud or has any concerns reference Fraud Bribery and Corruption can make a referral by contacting the Counter Fraud Department by either of the following methods;

1. Telephoning the office on 01267 248627,
2. Emailing HDUHB.CounterFraudTeam.HDD@wales.nhs.uk
3. Making an online referral at https://reportfraud.cfa.nhs.uk or
4. Making an anonymous referral by telephoning the Counter Fraud Reporting Hotline (Powered by Crimestoppers) on 0800 028 40 60.

Staff should refer to the Counter Fraud, Bribery and Corruption Policy (opens in a new tab) for further information.

Contents

Introduction

The Bladder and Bowel Advisory Service for Hywel Dda University Health Board (HDUHB) aims to promote continence by encouraging the use of continence care pathways and health promotion as first line strategies and discourage the use of incontinence pads before assessment and alternative strategies have been considered. The National Service Framework for Older People in Wales (WAG, 2006) requires that each health and social care provider develops and implements a written policy for continence care.

This policy identifies the requirements for an integrated service as defined in Good Practice in Continence Services (DOH, 2010) for the assessment, diagnosis, treatment and management of bladder and bowel dysfunction. This also complies with principles of The Health and Care Standards (WAG, 2015) and Health Quality Improvement Partnership (2010).

Poorly controlled bladder and bowel dysfunction can affect physical and psychological health which may involve other health services e.g. falls practitioners, tissue viability, frailty teams and mental health services. Incontinence is a primary reason for admission to care homes and outside of health care, incontinence can impact an individual's ability to work, study and socialise, potentially creating an increased reliance on benefit support and social isolation (Yates, 2021a).

It is critical that healthcare professionals are aware that incontinence is a symptom, not a disease, defined as 'the involuntary loss of urine or faeces, solid or liquid' (Abrams, 2017). Treatments are varied and it is therefore important to diagnose the cause(s) accurately and provide appropriate advice and appliances. There is an increasing body of knowledge about clinically proven treatments (see NICE 2007, 2008, 2010, 2012, 2013, 2015; 2017; 2019).

Robert Francis referred to continence as 'this most basic of needs', highlighting significant concerns within this area of care (Department of Health (DOH), 2010). In the 'Hard Truths' report, the Government made a commitment to ensuring that the fundamental standards of continence care that people have a right to expect and receive are met consistently, whatever the setting (DOH, 2013).

Prevalence Data for Urinary and Faecal Incontinence in the United Kingdom

United Kingdom (UK) prevalence data of urinary incontinence (UI) varies widely (5-69%) in women because of differences among populations studied, definitions, and measurements used. UI prevalence statistics are significantly under-reported due to the stigma surrounding continence issues. Research suggests that prevalence increases up to middle age, plateaus or decreases between 50 and 70 years of age, and rises again with advanced age. This increase in the older population may be due to higher rates of idiopathic detrusor activity and risk factors such as diabetes, limited mobility, menopause, and medication (Milsom & Gyhagen, 2019). Slight to moderate UI more frequently affects younger women and moderate and severe incontinence predominantly occurs in the older age group.

Whilst the prevalence of UI in women is higher than in men, lower urinary tract symptoms (LUTS) in men are common. Most elderly men have at least one LUTS; however, symptoms are often mild or not very bothersome according to the European Association of Urology (2018). Troublesome LUTS can occur in up to 30% of men older than 65 years of age as the prevalence of LUTS in men increases with age.

Conservative estimates suggest there are around 6.5 million people in the UK today with some form of bowel dysfunction i.e. faecal incontinence (FI) or chronic constipation (CC), which is 1 in 10 people

(Cost of Constipation Report, 2020). Bowel dysfunction has a significant impact on our health and wellbeing, research shows that CC causes people to suffer in silence and pain, leading to 71,430 hospital admissions in 2017/18, equivalent to 196 people a day.

The total cost for treating unplanned admissions due to CC in the United Kingdom is estimated at £71 million in 2017/18 (Cost of Constipation Report, 2020). Many people are needlessly suffering because of the taboo nature of the subject, and a lack of understanding of the issue. Ranging from the rate of hospital admissions to cost of laxative prescriptions (estimated cost of prescriptions; £54,000 per month across primary care in HDUHB -2019 figures) and time off work, the reduction in quality of life and breakdown of relationships, the impact of this seemingly innocuous symptom is far-reaching and occasionally shocking.

It is reported that FI affects between 1-15% of adults, depending on the definition employed. However, due to reluctance in reporting, prevalence data on FI is thought to be gravely underestimated. Data supports that FI is more common in the elderly population with 15% of over 70s and nearly half of nursing home residents affected. It is the second leading cause of nursing home placement (second to dementia) in the UK (Cost of Constipation Report, 2020).

Policy statement

Hywel Dda University Health Board (HDUHB) has a responsibility to ensure that during the process of caring for patients, they are protected from avoidable harm. Continence care must be performed in accordance with evidence-based practice, professional standards and within a recognised legal and professional framework. The philosophy of the Bladder & Bowel Advisory Service is that through improvements and consistency in continence care we can provide individualised care that results in:

- A better quality of life and more independence by implementing solutions related to individual need
- Less reliance on incontinence pads by using alternative appliances, health promotion and evidence-based strategies
- A reduction in admission to hospitals and care homes for continence related symptoms
- Fewer complications, such as urinary tract infections, faecal impaction and skin breakdown
- A reduction in cost; both personal and financial

Scope

This policy applies to all healthcare professionals employed by HDUHB who are responsible for the care of adults and children experiencing bladder and bowel dysfunction and/or incontinence. This policy is intended to support all employees within HDUHB involved in any aspect of continence care. This includes locum, bank or agency staff and any members of staff undergoing training e.g. pre-registration student nurses and midwives. The policy is provided as a reference source for all healthcare professionals. The principles of this policy are considered best practice and it is recommended that they are adopted by Nursing and Residential care homes and independent providers of care in the health board locality.

Aim

The aim of this document is to:

- To promote high quality continence care to individuals within HDUHB who experience bladder and /or bowel dysfunction.
- To provide guidance on promoting continence and managing individual continence needs.

- To meet the continence needs of all individuals respecting culture, diversity, and sexuality.
- Continence care must be person-centred, planned in conjunction with the multi-disciplinary team, and where appropriate extended to the individual's family and/or significant others.
- Healthcare professionals are individually accountable for the care provided hence, it is imperative that continence care is ingrained in evidence based clinical practice (NMC, Code of Professional Conduct 2018 a&b)

Objectives

The aim of this document will be achieved by the following objectives:

- Providing guidance, training and support to all healthcare professionals including student nurses and midwives involved in the assessment, treatment and management of bladder and bowel dysfunction and continence care.
- Facilitating a consistent approach to continence assessment and management through evidence-based research and clinical guidelines.
- Promoting high quality and timely bladder and bowel care for every individual in HDUHB which complies with both local and national policies and guidelines.

Assessment Process

The All Wales Continence Forum Consensus Document 2022 (All Wales Continence Forum (AWCF), 2022) recommends that all patients must be asked, as part of a holistic assessment, if they have a bladder or bowel problem. For the purpose of this document the standard trigger question is "Do you have any problems with, or concerns about, your bladder or bowel?" If the answer is "yes" a full continence assessment must be completed.

A continence assessment must be completed using the following documentation:

- Current approved HDUHB primary/community and secondary care documentation (see Appendix 2 and Appendix 3) - opens in a new tab
- Bladder diary (see Appendix 7) - opens in a new tab
- Bristol Stool Chart & Bowel diary (see Appendix 8 and Appendix 9) - opens in a new tab
- Relevant risk assessment documentation (secondary care) – for example Purpose T (skin integrity) see Appendix 4 - opens in a new tab for discharge paperwork flow chart
- Request for incontinence products Adults/Paediatric (see Appendix 14 and Appendix 20 - opens in a new tab)

A first-line continence assessment can be performed by a healthcare professional, Band 4 and above who can demonstrate competence, knowledge, and skills relevant to this area of care and has evidence of appropriate training updates.

Continence reassessment can be delegated to non-registered allied healthcare professionals (for example band 2/3 healthcare support workers and student nurses and midwives) who can demonstrate appropriate theoretical knowledge, skills and competence. Clear lines of accountability and supervision must be maintained by the registered healthcare professional who delegates the task (NMC, 2018 a&b). All reassessments performed by non-registered healthcare professionals must be checked and countersigned by a registered healthcare professional (see 289 - Record Keeping for Nurses and Midwives Policy - opens in a new tab).

Once a continence assessment has been completed the assessor must:

- Explain the outcome of the assessment to the patient/carer
- Explain the proposed treatment options (e.g. conservative management techniques, pad products)
- Provide appropriate contact details for follow up advice / support
- Provide supporting health promotion information / advice (as required)

Information and education must be delivered in a clear and concise manner without using jargon, and where possible provided in both visual and auditory format. Health promotion advice must be delivered to improve symptoms of bladder and bowel dysfunction e.g. improving fluid intake, pelvic floor exercises (see Appendix 5). - opens in a new tab.

Following completion, all assessments must be forwarded to the appropriate Bladder and Bowel Advisory Service.

Pembrokeshire BABAS: Pembroke Dock Health Centre, Water Street, Pembroke Dock SA72 6DW Tel 01646 624644 Email BABAS.Preseli@wales.nhs.uk

Ceredigion BABAS: Training Room, Management Building, Bronglais General Hospital, Aberystwyth SY23 1ER Tel 01970 635962 Email Ceredigion.BABAS@wales.nhs.uk

Carmarthenshire BABAS: Room 6.23, Block 6, Prince Philip Hospital, Llanelli SA14 8QF Tel 01554 899039 Email Community.SupportServices@wales.nhs.uk

A Bladder and Bowel Clinical Nurse Specialist will review the assessment documentation and supporting information, and will either approve the request or return the assessment advising the assessor that additional information is required e.g. alternate delivery point, waist measurement or a substitute product must be offered.

Types of Incontinence

It is important to diagnose the type of incontinence the person is experiencing so that appropriate treatment and management strategies can be advised.

Stress Incontinence

Defined as the unintentional loss of urine on physical exertion such as coughing, laughing, sneezing, running or heavy lifting. This occurs when the pressure inside the bladder becomes greater than the urethral closure pressure and the urethral sphincter is not strong enough to close the urethra resulting in urine leakage. This is the most common form of urinary incontinence amongst women due to its association with childbirth and weakened pelvic floor muscles. Studies show that vaginal delivery has almost a two-fold increase in the risk of developing leakage compared with cesarean section (Tähtinen et al. 2016). Pelvic floor muscles can also become weaker in women because of changes to muscle tone and structure after menopause.

In men, the most frequent cause of stress incontinence is urinary sphincter damage acquired following prostate surgery or a fractured pelvis.

Aggravating factors include chronic coughing or sneezing due to illness or smoking, obesity and repeated lifting of heavy objects. Stress incontinence is not related to psychological stress.

Overactive Bladder (Urge Incontinence)
If the person feels a strong urge to urinate even when their bladder isn't full, the incontinence might be related to overactive bladder, sometimes called urge incontinence. This condition occurs in both men and women and involves an overwhelming urge to urinate immediately, frequently followed by loss of urine before they can reach a bathroom. Similarly, urinary frequency can interfere with work and social life because of the need to keep running to the bathroom.

Urgency is triggered by the detrusor muscle, which begins to contract and signals a need to urinate, even when the bladder is not full. Another name for this phenomenon is detrusor over activity.

Overactive bladder can result from physical problems that prevent the body from halting involuntary bladder muscle contractions. Such problems include damage to the brain, the spine, or the nerves extending from the spine to the bladder - for example, from an accident, diabetes, or neurological disease. Irritating substances within the bladder, such as those produced during an infection, might also cause the bladder muscle to contract.

Often there is no identifiable cause for overactive bladder, however, people can develop the problem as they age. Postmenopausal women tend to develop this condition, due to age-related changes in the bladder lining and muscle. A condition called myofascial pelvic pain syndrome has been identified with symptoms that include overactive bladder accompanied by pain in the pelvic area or a sense of aching, heaviness, or burning.

In addition, infections of the urinary tract, bladder, or prostate can cause temporary urgency. Partial blockage of the urinary tract by a bladder stone, a tumour (rarely), or, in men, an enlarged prostate (a condition known as benign prostatic hyperplasia, or BPH) can cause urgency, frequency, and sometimes urge incontinence. Surgery for prostate cancer or BPH can trigger symptoms of overactive bladder, as can freezing (cryotherapy) and radiation seed treatment (brachytherapy) for prostate cancer.

Neurological diseases (such as Parkinson's disease and Multiple Sclerosis) can also result in urge incontinence, as can a stroke. When hospitalised following a stroke, 40% to 60% of individuals experience incontinence.

Mixed Incontinence
Symptoms of both overactive bladder and stress incontinence are considered mixed incontinence, a combination of both types. Most women with incontinence have both stress and urge symptoms - a challenging situation. Mixed incontinence also occurs in men who have had prostate removal or surgery for an enlarged prostate, and in frail older people of either gender.

Overflow Incontinence
If the bladder never completely empties, people might experience urine leakage, with or without feeling a need to go. Overflow incontinence occurs when something blocks urine from flowing normally out of the bladder, as in the case of prostate enlargement that partially closes off the urethra. It can also occur in both men and women if the bladder muscle becomes underactive (the opposite of an overactive bladder) so there is no sensation to urinate. Eventually the bladder becomes overfilled, or distended, pulling the urethra open and allowing urine to leak out. The bladder might also spasm at random times, causing leakage. This condition is sometimes related to diabetes or cardiovascular disease.

Men are much more frequently diagnosed with overflow incontinence than women because it is often caused by prostate-related conditions. In addition to enlarged prostate, other possible causes of urine blockage include tumours, bladder stones, or scar tissue. If a woman has severe prolapse of their uterus or bladder (meaning that the organ has dropped out of its proper position), their urethra can become kinked, interfering with the flow of urine.

Nerve damage (from injuries, childbirth, past surgeries, or diseases such as diabetes, Multiple Sclerosis, or shingles) and aging often prevent the bladder muscle from contracting normally. Medications that prevent bladder muscle contraction e.g. antimuscarinics can also result in overflow incontinence.

Functional Incontinence
If the urinary tract is functioning but other illnesses or disabilities are preventing people from staying dry, they might be experiencing functional incontinence.

For example, if an illness rendered a person unaware or unconcerned about the need to find a toilet, they would become incontinent. Medications, dementia, or mental illness can decrease awareness of the need to find a toilet.

Even if the urinary system is functional, it can be extremely difficult to avoid accidents if people have trouble accessing a toilet. This problem can affect anyone with a condition that makes it excessively difficult to move to the bathroom and undress in time. This includes problems as diverse as having arthritis, being hospitalised, or restrained, or having a toilet located too far away.

Medications such as a diuretic (used to treat high blood pressure or heart failure), can cause a person to produce abnormally large amounts of urine, which could lead to incontinence that requires a change in treatment. If a person produces most of their urine at night, the result might be nocturnal incontinence, or bedwetting.

Reflex Incontinence
Reflex incontinence occurs when the bladder muscle contracts and urine leaks (often in large amounts) without any warning or urge. This can happen as a result of damage to the nerves (neuropathy) that normally warn the brain that the bladder is filling. Reflex incontinence usually appears in people with serious neurological impairment from Multiple Sclerosis, spinal cord injury, other injuries, or damage from surgery or radiation treatment.

Faecal Incontinence
The symptoms of bowel incontinence can vary from person to person. Some people feel a sudden urge to go to the toilet but are unable to reach a toilet in time. This is known as faecal urge incontinence. Other people experience no sensation before soiling themselves, known as passive incontinence or passive soiling/smudging, or there might be slight soiling when passing wind. Some people experience faecal incontinence daily, whereas for others it happens from time to time. Faecal incontinence is a symptom, not a diagnosis. Faecal incontinence may present due to various causes e.g. constipation (overflow) or diarrhoea (infective), see Bristol Stool Chart for types of stool (See Appendix 8). – opens in a new tab.

Appliances and Adaptions

Specialised equipment, appliances and adaptations are a key factor in enabling an individual to manage their incontinence as independently as possible whilst maintaining privacy and dignity. Basic equipment such as commodes and urinals are available locally to help promote continence care. The Bladder and Bowel CNS team have expertise in identifying the most appropriate products and can make recommendations on their usage. A referral to a physiotherapist and/or occupational therapist for aids and adaptations may further support an individual to maintain and/or manage their continence.

Patients must not be catheterised for urinary incontinence per HDUHB 396 Adult Catheterisation Policy. – opens in a new tab. Seek advice from the Bladder and Bowel Advisory Service regarding clinical justification for urinary indwelling catheters.

Handheld Urinals

Handheld appliances are designed to be used by the patient or carer and are often smaller than traditional urinals or bed pans. They are invaluable for those who have impaired mobility and are unable to transfer to the toilet quickly.

Funnels and Directors

Some men suffer from penile retraction and/or a poor flow of urine and often present with soiling of underwear and clothes. If there is ample length of penis, a urine director may prove useful in directing urine away from the body into the toilet bowl. Female urinary funnels are available for ladies who find that their stream of urine sprays outwards when sitting on the toilet.

Urinary Sheaths/Pouches

Urinary sheaths are made from a soft, flexible latex or silicone tubing that is placed over the penis to facilitate the drainage of urine away from the body into a drainage bag. When a urinary sheath is correctly fitted the skin does not become contaminated with urine. Sheaths can be used with male patients who have moderate to severe urinary incontinence. Each patient should be individually assessed for:

Correct length (standard, short & pop-on available)
Sizing (measurement devices are available for all brands of sheath)
Sheath style (e.g. latex free, aloe vera for sensitive skin)
Drainage system - appropriate to individual need e.g. 500mls leg bag

Sheaths must be changed daily to aid pressure relief, personal hygiene, and assessment of skin integrity. Soap and water are advised for sheath removal, however in the unlikely event of a chronic problem, consider using a spray adhesive remover. Specialised sheaths for gentlemen who have problems with the sheath coming off due to the high force urinary flow are available. Contact your local Bladder and Bowel Advisory Service or Cobweb Prescription Service on 0800 804 8787 for advice about sheaths or the supply of sheath measurement devices.

Faecal Containment Products

Anal Plugs

Disposable, soft appliance suitable for faecal leakage/seeping, however a plug will not contain a formed bowel movement. Anal plugs must only be prescribed following assessment by a Bladder and Bowel Clinical Nurse Specialist.

Drainable Faecal Pouch Collector
Disposable faecal containment bag applied to the perianal area, which has an adhesive hydrocolloid pad to hold the bag in place. This appliance may benefit someone whose skin integrity is reduced.

The Importance of Physiotherapy in Continence

“Physiotherapy is by far the most cost-effective intervention for preventing and treating mild to moderate incontinence and prolapse”. (NHS, 2019 pg. 54) Improvements in social, physical and mental functioning have been demonstrated in those conducting pelvic floor muscle training (Radzimińska et al, 2018). Pelvic floor dysfunction can affect an individual throughout their life course and affect both women and men, due to chronic constipation, pregnancy, childbirth, obstetric injuries, menopause, older age, post-surgery, radiotherapy, and occupational factors (POGP, 2021).

Urinary incontinence is also found to affect high performance athletes, with them being three times more likely to experience urinary incontinence than women of a similar age and obstetric history (Carvalais et al, 2018). Pelvic health physiotherapy has been found to demonstrate increased confidence outcomes in women participating in high level aerobic activities (Somingueta-Hernández et al, 2020).

Pelvic health physiotherapy assessment includes undertaking a detailed subjective assessment of the individual’s bladder, bowel, obstetric, gynaecological, social, and medical history, prolapse, pain and sexual symptoms. Pelvic health physiotherapists have established and demonstrated competence in the examination, assessment and interventions related to the pelvic floor complex (CSP, 2012). Pelvic floor muscle training is thought to lead to a decline in detrusor pressure and increase in urethral pressure and a suppression of the micturition reflex (Bø et al, 2020), combining this with bladder training and particularly bladder drill training can be beneficial in managing symptoms of overactive bladder.

The assessment of pelvic floor via digital vaginal or ano-rectal examination following full explanation and written informed consent can assess many aspects of pelvic floor dysfunction.
Muscle strength is assessed using the modified Oxford scale, allowing for augmentation + or – when appropriate. Endurance is measured as the length of time a maximal voluntary contraction can be sustained. The number of repetitions that can be repeated at the same level of contraction and the number of fast (1 sec) maximal voluntary contractions. This P.E.R.F.ECT scheme allows for assessment of the point in which the pelvic floor can be over-loaded and produce a training effect and plan a programme of exercise. (Laycock and Jerwood, 2001)

Pelvic organ prolapse can contribute and co-exist with incontinence symptoms and other pelvic floor dysfunctions (Hunskaar et al, 2005). Individualised supervised pelvic floor muscle training has been shown to reduce symptoms and staging of pelvic organ prolapse and reduce reported urinary incontinence symptoms (Haagen et al, 2014). An assessment of staging of prolapse is conducted in both lying and functional positions such as standing, squatting or lunging depending on the patients’ reported symptoms.

Urinary symptoms often co-exist alongside chronic pelvic pain conditions such as bladder pain syndrome (BPS) and interstitial cystitis (IC). It is thought that changes occur in the afferent nerves of

the bladder lining leading to increased frequency and urgency. The pelvic floor within people with BPS has been shown to be less mobile and painful on palpation, this means it has reduced ability to perform reflex action to inhibit detrusor. These changes can be maintained by central sensitisation (Bond et al 2017).
A multidisciplinary approach to treating the symptoms is recommended by Engeler et al (2010). Physiotherapy aims to restore normal pelvic floor tension and range of movement and desensitise muscle nociception and restore normal bladder and bowel function (Bø et al 2015).

Furthermore, the assessment of obstetric anal sphincter injuries (OASI) and optimisation of continence works alongside the management of wounds and scar tissue. Physiotherapy following OASI repair is thought to be beneficial in reducing faecal incontinence, faecal urgency, dyspareunia, and perineal pain (RCOG, 2015, Tam et al 2013)

Once first line treatment options such as pelvic floor muscle training, lifestyle and behaviour modifications have not been found to be beneficial, other treatment options can be considered including:

Biofeedback: this can used in many ways including EMG units, real time ultrasound, and pressure biofeedback. Biofeedback can be used to improve sensitivity, improving strength and co- ordination as part of a rehabilitation programme (Norton and Cody 2012). Point of contact ultrasound (POCUS) can enhance therapeutic regimes, improving patient understanding and compliance as well as offering a non-invasive means for assessment for both men and women who may not consent to internal assessment or are unable to tolerate such an assessment (Dixon J, 2021). As POCUS is not regulated practice by law, clear levels of clinical speciality to work with a scope of practice is necessary and clear differences identified between those practicing diagnostic ultrasound and point of contact ultrasound (HCPC, 2021, BMUS, 2009).

Neuromuscular Electrical Stimulation (NMES): can be indicated if a patient is unable to actively contract their pelvic floor, this can be due to neurological disease such as multiple sclerosis (MS) or nerve damage to the sacral nerve complex or the pudendal nerves. This has been found that NMES could be considered first line treatment for individuals with urinary incontinence with MS (McClurg et al, 2008). This can be done per vagina or per rectum or by transcutaneous nerve stimulation via the tibial nerves, however this is not supported by recent guidelines (NICE, 2019).

Criteria for Continence Pad Provision

Clinical assessment, in line with current Welsh guidance and personalised care planning is a fundamental activity guiding best practice for the provision of containment products for adults and children in Wales. This is essential prior to identifying management options and consideration of the use of containment products.

Incontinence pads will only be supplied on identification of clinical need following a comprehensive continence assessment and accompanied by a care plan which identifies containment of urine and/or faeces with pads as being the most appropriate mode of management, with all other options having been explored.

Promotion of continence should always be the priority. The Bladder and Bowel Advisory Service advocate that conservative interventions must be attempted and evaluated before pads are considered. Low-cost community interventions can cut containment product usage by 50% (Imamura M et al, 2010).

An individual's vulnerability to developing moisture lesions is exacerbated when both faecal and urinary incontinence is present (Voegeli, 2010).

The process of identifying, assessing, and treating continence issues can significantly reduce problems with skin integrity thus reducing moisture lesions and pressure ulcers (All Wales Best Practice Statement on the Prevention and Management of Moisture Lesions, 2014). Continence care should be supported through a multidisciplinary approach to support individuals with toileting programmes and functional incontinence, reducing the need for containment products.
Containment products are used to support toileting regimes and individuals should not be told to urinate or defecate in a pad unless individual safety is compromised and should never be used as a replacement for a toileting programme.

National and Local Guidance on the Provision of Contaminated Products
Current national and local guidance assumes that clinical assessment and first-line treatment has taken place, and the patient has a clinical need for product provision. However, there are exceptions for individuals who have limited life expectancy and are receiving end of life care.

Once a person has been assessed, it may be helpful to trial a product to ensure that the item/s provided are acceptable for the person receiving the product. Speak to your local Bladder and Bowel Advisory Service for information on samples. Continence products and appliances must be self-purchased until an assessment has taken place.

Reassessment of products should be carried out 6 or 12 monthly, or as needs/ circumstances govern e.g. transition from child to adult, health deterioration. Individuals moving to Wales from another country will require a new assessment as formularies differ between NHS providers.

All in-patient wards and depts. must provide patients with an adequate supply of products if continence symptoms have not resolved prior to discharge. The ward/dept. must have a robust discharge process in place to ensure individuals are assessed for appropriate product provision and referred to the relevant community service for reassessment prior to discharge.

Inpatient wards and departments must adhere to the HDUHB hospital product formulary (see Appendix 12 - opens in a new tab) which aligns with community services formulary (see Appendix 11 - opens in a new tab). If clinical assessment identifies a need outside of the formulary, advice must be sought from your local Bladder and Bowel Advisory Service.

Containment products will not be provided for menstruation, acute incontinence secondary to urinary tract infection, rectal bleeding or for wound dressing regimes.

Washable products should be considered as first line choice for light to moderate incontinence - a maximum of 6 pairs per year will be provided by HDUHB. When sizing washable containment underwear, provide waist and hip measurements for females and for males, a waist measurement is required. See formulary (see Appendix 10) - opens in a new tab, for full range of products.

The number of disposable, pad products issued by HDUHB, will not normally exceed 4 per 24 hours. This takes into consideration fluid intake, frequency of carer visits and any associated incontinence. It is appropriate to provide a lower number of pads initially and increase if/when necessary. The Bladder and Bowel Advisory Service are mindful that there are exceptional circumstances which may

necessitate an increased supply. This increase must be authorised by a Bladder & Bowel Clinical Nurse Specialist upon receipt of clinical justification.

HDUHB will not provide containment pads for 'just-in-case' purposes or very light incontinence (where one single, incontinence pad, panty-liner or sanitary type towel is worn per day). People will be required to self-purchase in line with prudent prescribing principles.
If an individual has an indwelling urinary or suprapubic catheter and experiences faecal incontinence, the assessor must stipulate whether faecal smearing or complete bowel actions are evident. Pull up pants and Slip 'nappy' style will not routinely be provided for catheterised individuals. If an individual is suffering from unresolved chronic urinary catheter bypassing (despite intervention and conservative treatments), and is waiting on urology follow up, we will supply a suitable, appropriate containment product e.g., rectangle pad.

In some circumstances a mixture of absorbencies may be required to manage incontinence effectively e.g., a higher absorbency for night-time. However, clients must wear the lowest absorbency product required to prevent moisture lesions from developing.

Patients using FORM products must wear net fixation pants or their own form-fitting underwear. Ensure you obtain a waist measurement to prevent pressure damage around groin and abdomen. A limited supply (5 per year) of washable net fixation pants will be supplied to wear with FORM pads. Any additional fixation pants must be self-purchased by the individual.

The use of a two-piece system must be promoted where possible. Shaped pads (FORM) are HDUHBs product of choice rather than (SLIP) 'nappy' style products which hinder toileting and are undignified to wear when ambulatory.

Slip (nappy-style) should not be issued for individuals who are able to use the toilet/commode. These products are very difficult for individuals to self-manage and may result in over-balancing, potentially resulting in a fall. Slip products will not be provided for individuals with 24-hour care provision where carers can assist with a two-piece system or where care staff solely manage continence needs. Requests for Slip products will be assessed on individual need.

These products should be reserved for:

- Containment of infectious, watery diarrhoea (e.g., norovirus or c-difficile).
- Individuals who have contracted limbs and/or painful to move.
- Bed-bound individuals where a two-piece system has shown to be ineffective.
- Very heavy urinary incontinence where a shaped pad has shown to be ineffective.

Washable Bed Pads are not routinely provided. In exceptional circumstances where body worn products cannot be worn a maximum of 2 per year will be provided. In rare instances, products within the formulary may not be suitable or effective for a particular individual; seek advice from the Bladder and Bowel Advisory Service.

Individuals who have regular bowel interventions performed e.g., manual evacuation /enemas etc. will be supplied with 1 procedure pad/ per day for <u>procedural</u> use only. These are NOT to be used for urinary or faecal incontinence. In exceptional circumstances e.g., for individuals on the Last Days of Life pathway, the use of a procedure sheet as opposed to a body-worn product might be the most appropriate option and consideration will be given to this.

Visitors (e.g., on holiday) to the HDUHB locality will not have products provided.

Containment products must only be worn by the individual for whom they have been assessed and prescribed. Clients must not share their products with family members/neighbours. Under no circumstances should products allocated to one patient be used by another. If this occurs without due process being followed, then such instances will be referred to the Health Boards Counter Fraud Team.

At no point should products be ordered via the HDS for NHS nursing-funded clients. Products must be purchased via the care home concerned. Should products be ordered via the HDS, this would constitute a double order, which is prohibited under the policy.

When an eligible residential-funded care home resident passes away, the HDS must be informed immediately, and no further products ordered. Any unopened packets must be returned to the HDS as per section 10.2. Instances of repeat ordering for a deceased client may result in a referral to the Health Boards Counter Fraud team.

Where the health board provides funding for an individual who requires residential care outside of the health board boundary, the health board where the individual *mainly* resides will be responsible for the cost of containment products. The funding health board may be responsible for products provided during i.e., school holidays, but this agreement will be after cross-border discussions.

NHS health boards do not have a duty to supply containment pads but do so at their discretion and within the resources available to them. Individuals are required to 'top up' or purchase their own supplies if they require a volume or style of product outside the formulary or outside the recommendation of the assessing healthcare professional.

Special order items (see Appendix 13 - opens in a new tab) must be requested with fully completed continence assessment documentation and a letter outlining your clinical justification. These items must be authorised by a Bladder and Bowel clinical nurse specialist.

Bladder and Bowel Home Delivery Services (HDS)
All products will be delivered to community dwellings and residential care homes via the nominated (Home Delivery Service) HDS at 8 weekly intervals.

The use of a Continence Observation Chart (see Appendix 21 - opens in a new tab) may be requested from residential settings and should be presented with the main continence assessment. This document is used to support training needs and awareness to staff of the need to provide regular toileting as opposed to relying on pads.

Complete packs of unused pads must be returned to the HDS, contact your local Bladder and Bowel Advisory Service or HDS administrator for advice/and or to arrange collection. Note there may be slight changes to collection procedures due to Covid-19. Check for updates with the Bladder and Bowel Advisory Service.

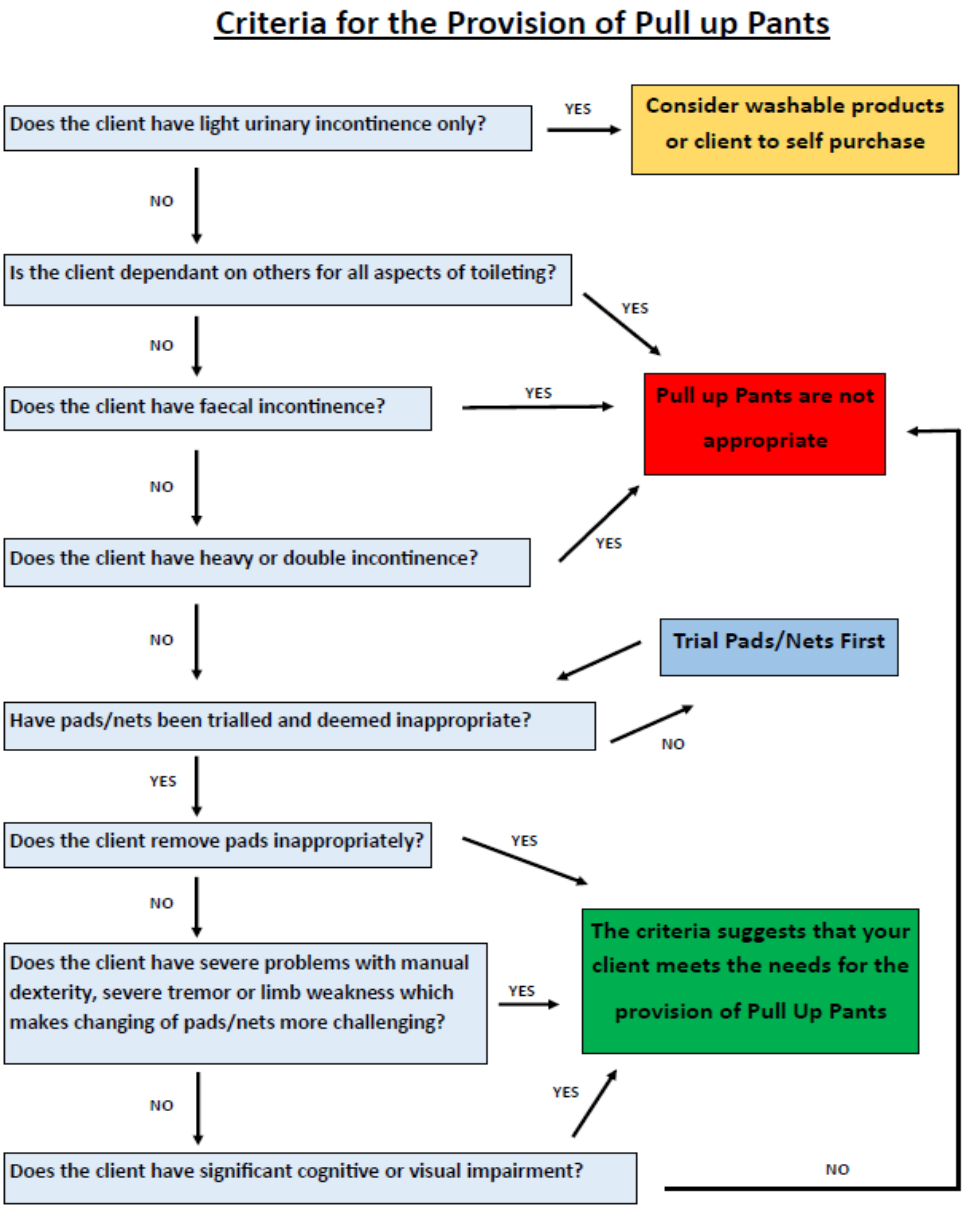
A dispatch note will be provided with every delivery. The note contains the HDS telephone number and date of next delivery. It is the responsibility of the client, carer or significant other to call and activate the

next delivery a week prior to the delivery due date. In extraordinary circumstances, BABAS will implement an automated delivery schedule.

All Wales Guidance for Assessment and Issuance of Pull up Pants

'Pull-up' disposable pants will only be prescribed for individuals who have physical or mental impairment, where it has been assessed that they are able to use the product independently, are mobile and are unable to use a shaped pad with nets or close-fitting underwear. If a caregiver assists with pulling the pants up and down, and/or toileting then shaped pad & nets will be provided. Supply will not exceed 3 pairs of pull-on pants per 24 hours. Pull-ups will be provided based on clinical need and only with authorised signatory from the Bladder and Bowel Advisory Service. All staff are responsible for managing resources effectively, efficiently and economically.

Consider the following questions before issuing pull-up pants.



Moisture Lesions and Skin Integrity

Incontinence associated dermatitis (IAD) and pressure ulcers are a national priority and the process of identifying, assessing, and treating continence issues can significantly reduce problems with skin integrity.
https://www.wwic.wales//uploads/files/documents/Professionals/New%20Articles/MASD.pdf (opens in new tab).

Health professionals must adhere to current HDUHB formulary continence selection guides. It is critical that the person is provided with the correct absorbency and size of pad otherwise the product will be ineffective and can contribute to the formation of moisture lesions e.g., a highly absorbent pad will cause intact skin to dry out if the person has light incontinence. Similarly, a product that is not absorbent enough will not absorb urine/faeces from the skin and result in sore, excoriated skin (Bardsley, 2012).

Urinary and faecal incontinence are both key contributors to the formation of moisture lesions and have a profound and devastating effect on a person's social, physical, financial, and psychological wellbeing (Bardsley, 2012). Prolonged contact of the skin with urine, faeces or both can result in the skin becoming over-hydrated or macerated, which can make skin more prone to bacterial infection. Skin also becomes more susceptible to physical damage leading to extremely painful areas of pressure damage which can cause severe debilitation (Beldon, 2008).

It is important that any person identified with continence issues who has a high risk of developing moisture lesions be assessed by a competent healthcare professional with knowledge of the continence assessment process and tissue viability recommendations regarding appropriate and evidence-based skin care regimes.

Secondary Care (in-patient) Assessment and Provision of Containment Appliances

The provision of absorbent incontinence products must be based on person-centred, holistic assessment and subsequent selection of an appropriate product, as indicated. To maintain continuity of care, every inpatient dept. must stock a standard range of products from the HDUHB hospital formulary (see Appendix 12 - opens in a new tab) to appropriately address individual continence needs.

On admission, the Continence Promotion Care Plan 11.1 (see Appendix 3 - opens in a new tab) must be initiated by a registered healthcare professional if bladder or bowel dysfunction/incontinence is identified, and a bladder and bowel toileting care plan must be commenced.

During hospital admission every effort must be made to encourage families / carers or significant others to provide any current continence products already in use within community settings.

Secondary care services must also adhere to the All-Wales standards set out in this policy.

Prior to discharge, the ward/department must provide appropriate HDUHB documentation (see Appendix 4 - opens in a new tab) and forward to the Bladder and Bowel Advisory Service. The ward/department must provide an adequate supply of products while the person awaits their first delivery (usually a one-week supply). Incomplete assessments will be returned, delaying the delivery of containment products. Contact a member of the Bladder and Bowel Advisory Service for advice on documentation.

Consent and Mental Capacity

Individuals have a legal and ethical right to determine what happens to their own bodies. As with any aspect of care, consent for assessment must be obtained in advance of the process taking place. For consent to be valid it must be given freely, and the individual must be properly informed. Verbal consent (which must be clearly documented in the notes) is required for all aspects of care. Consent

must only be taken by a healthcare professional who is competent in all aspects of the assessment. Ideally, the individual who obtains consent should be the person conducting the assessment.

Before an individual can give their informed consent, they must be provided with information in relation to the purpose and nature of the assessment.

Individuals who may lack Capacity to Consent for Themselves
Where a healthcare professional decides that an individual is unable to validly consent to or decline a proposed continence assessment, evidence for those concerns must be documented so a record of an appraisal of decision-making capacity can be made. In most instances it is highly likely to be in a person's best interests to receive the proposed assessment, however the healthcare professional will need to consider the ascertainable wishes and feelings of the individual and, where practical, consult with people close to them. Further support and information are available within the HDUHB 811-Mental Capacity Act Practice Guidance.

End of Life Continence Care

If containment products (pads) are required for end-of-life care, contact the Bladder and Bowel Advisory Service who will fast track your request. The concern for quality of life is imbedded in the philosophy of end-of-life nursing care. Key components of end-of-life care include effective communication, assessment and care planning, symptom management, comfort and wellbeing, and advanced care planning. The Bladder and Bowel Advisory Service observes HDUHB end of life guidelines and All Wales Guidance: Care Decisions for the Last Days of Life (Wales Palliative Care Forum (WPCF), 2021) which acknowledge that;

- Aspects of bowel and urinary dysfunction are not always predictable.
- It is not easy to maintain a patient's dignity whilst providing intimate care associated with continence.
- Neither is it always possible to involve patients in decision making at this stage of life.
- Continence care at end of life must be evidence based and the healthcare professional must remain ever mindful that dignity and quality of life are paramount.

Poorly managed bowel and bladder symptoms can lead to disabling complications for the individual, often causing secondary problems such as urinary retention and delirium. A dying person with a full, uncomfortable rectum or distended bladder may present with terminal agitation and restlessness.

The management of urinary symptoms at the end of life focuses on containment of urinary incontinence, comfort and dignity and management of retention. Catheterisation is an invasive procedure, and it is therefore important to explore alternatives including pads, portable urinals, urinary sheaths, urinary and faecal pouches.

The Dying Process and Bowel Symptoms
It is a myth that patients who are unable to eat will not need to open their bowels. Faecal matter continues to be formed even if a patient is cachexic. Approximately 50% of faecal content consists of unabsorbed gastrointestinal secretions, shed epithelial cells and bacteria.
Bowel interventions for severe constipation or faecal loading are invasive and uncomfortable particularly in the last hours of life and need to be prevented. Literature suggests that the need to treat constipation is a failure in prevention. A proactive approach needs to be adopted to prevent constipation or faecal loading occurring at the end of life (WPCF, 2021).

All Wales Criteria for the Provision of Containment Pads for Children and Young Adults

All children and young people must receive support to achieve their maximum continence potential, regardless of age, culture, or physical and psychological ability. Containment products must only be supplied following a full assessment by an appropriately trained health care professional e.g. health visitor, school nurse and only when toilet training is not deemed as achievable.

Comprehensive information from the Guidance for the Provision of Continence Containment Products to Children and Young People – A consensus document (2021) aims to facilitate a consistent and equitable approach to the provision of containment products to children and young people by bringing together a consensus of agreement, combining available evidence from the literature and clinical expertise. see Appendix 15, Appendix 16, Appendix 17, Appendix 18, Appendix 19 and Appendix 20 - opens in a new tab, for assessment documentation.

Assumptions must not be made regarding the ability, or lack of ability of children and young people with additional needs to be toilet trained. Continence must be promoted at all times and as stated by All Wales Guidance (2021)*... 'The provision of continence products to this group of children must be the exception rather than the rule'.* Failure to ensure that children and young people experiencing symptoms of incontinence undergo a comprehensive bladder and bowel assessment may result in serious underlying problems, such as neuropathic bladder or bowel, or chronic constipation going undiagnosed and untreated.

See link below for full document: Guidance for the Provision of Continence Containment Products to Children and Young People https://www.bbuk.org.uk/wp-content/uploads/2021/06/Guidance-for-the-provision-of-continence-containment-products-to-children-2021.pdf (opens in new tab).

Key Recommendations

Reassessment of products need should be carried out annually or as needs/ circumstances change e.g., transition from child to adult. Children transferring into Wales who already receive containment products must have a new assessment.

Parents/care givers must purchase products until an assessment has taken place.

This document aims to facilitate a consistent and equitable approach, to continence care for all children and young people aged 0–19 and to the provision of containment products to children and young people from the age of 5 years old, who are not able to become continent within six months of engagement with appropriate support, interventions, and/or toilet training programmes, by bringing together a consensus of agreement, combining the available evidence from the literature and clinical expertise.

However, there will be times when individually assessed circumstances warrant an approach outside the guidance. The expectation is that health care staff will use clinical judgement, medical, nursing, and clinical knowledge in applying the general principles and recommendations contained in this document. Recommendations may not be appropriate in all circumstances and the decision to adopt specific recommendations should be made by the practitioner, considering the individual circumstances presented by each child and young person, as well as the available resources. Therapeutic options should be discussed with the family, child, and clinicians on a case-by-case basis, as appropriate.

Products will not be issued to children who have enuresis or encopresis as these are deemed treatable conditions. Containment products must not be supplied for treatable medical conditions, such as bedwetting and constipation with overflow. These children and young people must be offered assessment and treatment by children's continence services.

All children and young people must be supported with a toilet training programme for at least six months, prior to providing containment products, unless it is clear that this is inappropriate e.g. in children with a neuropathic bladder and/or bowel.

The 'custom and practice' of automatically providing products to children with an acknowledged disability once they have reached their fifth birthday is not appropriate and could be considered discriminatory.

The number of products issued per 24 hours would normally not exceed 4, but in exceptional circumstances, provision will meet assessed individual need.

The use of two-piece system (pad & pants) must be considered wherever possible instead of an all-in-one (nappy) or disposable pull-up pant style product.

Disposable pant style products must not be provided as part of toilet training programmes for children with additional needs.

Consideration must always be made regarding the provision of washable products rather than disposable – clinical experience has shown that they are effective in supporting toilet training and help 'normalise' the process.

Clear plans and pathways must be in place to ensure the smooth transition from paediatric to adult services for those young people requiring ongoing support and product provision as they move into adulthood.

Responsibilities

Chief Executive
The Chief Executive has a responsibility for ensuring the health board employs a comprehensive strategy to support the management of risk, including clinical risks associated with patient care.

Director of Nursing, Quality and Patient Experience
The Director of Nursing & Quality has a responsibility to ensure that systems are in place for healthcare professionals to achieve the standards outlined in this document.

Service Manager/Lead Nurse
The Service manager/lead nurse has a responsibility to ensure that resources are available to adhere to the objectives of the policy.

Bladder and Bowel Advisory Service
The Bladder and Bowel Advisory Service are responsible for:
Providing specialist advice and support, to enable healthcare professionals to conduct continence assessments for patients in all care settings.

Developing and updating local policies which incorporate national evidence-based clinical practice guidelines and pathways of care to support Health Board implementation and evaluation.

Monitoring quality through clinical audit, considering comments and complaints.

Working in partnership with other organisations (e.g. other health boards, trusts, and statutory and voluntary organisations).

Providing competency-based education and training programmes to all levels of staff and the multi-disciplinary team. The team will ensure that systems are in place to identify training needs and that training is provided in a way that meets the learning needs of health professionals.

Delivering a high quality, cost-effective service within the resources available.

Ensuring access to current evidence regarding promotion of continence and management of bladder and bowel dysfunction.

Healthcare Professionals
Are responsible and accountable for their own practice when delivering continence care (NMC, 2018).

Are responsible for accessing and attending training sessions provided by the Bladder and Bowel Advisory Service in order to maintain their knowledge, competency and skills.

Will initiate and deliver continence care procedures and provide health promotion advice to maintain continence and treat/manage any symptoms of incontinence.

Are responsible for adhering to formulary guidelines and HDUHB policy in relation to continence appliances

Healthcare support workers, student nurses and midwives will work under the supervision of a registered healthcare professional in the application of this policy and are responsible for communicating actions and observations related to continence care to the registered healthcare professional.

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Appendix 1 – Bladder and Bowel Community Clinical Referral Form

Bowel and bladder community clinical referral form - opens in a new tab

Appendix 2 – Community Bladder and Bowel Assessment Form

Community bladder and bowel assessment form – opens in a new tab

Appendix 3 – Secondary Care 11.1 Continence Care Plan

Secondary Care Continence Care Plan – opens in a new tab

Appendix 4 – Continence Discharge Flow Chart for Secondary Care (in-patient wards/depts)

Continence discharge flow chart for secondary care – in patient wards/departments – opens in a new tab

Appendix 5 – Pelvic Floor Exercises for Men and Women

Pelvic floor exercises for men and women – opens in a new tab

Appendix 6 – Bladder Retraining Techniques

Bladder retraining techniques – opens in a new tab

Appendix 8 – Bristol Stool Chart

Bristol Stool Chart – opens in a new tab

Appendix 9 - Bowel Diary (example)

Bowel diary (example) – opens in a new tab

Appendix 10 – Continence Formulary: Washables

HDUHB Washable product selection guide – opens in a new tab

Appendix 11 – Continence Formulary: Community

Continence Formulary – Community – opens in a new tab

Appendix 12 – Continence Formulary: Hospital Wards/Depts.

Continence Formulary: Hospital Wards/Departments – opens in a new tab

Appendix 13 – Continence Formulary: Special Order Items

Continence Formulary: Special Order items – opens in a new tab

Appendix 14 – Continence Formulary: Order Form – Adults

Continence Formulary: Order form – adults – opens in a new tab

Appendix 15 – Continence Formulary: Children and Young People

HDUHB Childrens Product Selection Guide– opens in a new tab

Appendix 16 – Children and Young Person: Assessment Guidance

Children and young person assessment guidance – opens in a new tab

Appendix 17 – Children and Young Person: Toileting/Bladder and Bowel Diary

Children and Young people: Toileting bladder and bowel diary – opens in a new tab

Appendix 18 – Children and Young Person: Toileting Skills

Children and Young people: Toileting skills – opens in a new tab

Appendix 19 – Children and Young Person: Assessment Form

Children and young person Assessment Form– opens in a new tab

Appendix 20 – Children and Young Person: Order Form – Paediatric

Children and Young person Order form: Paediatric – opens in a new tab

Appendix 21 – Continence Observation Chart (Residential Care)

Continence observation chart – residential care