PROCEDURE FOR THE ASSESSMENT OF ADULTS AND CHILDREN WITH BLADDER OR BOWEL DYSFUNCTION

<table>
<thead>
<tr>
<th>First Issued</th>
<th>Issue Version</th>
<th>Purpose of Issue/Description of Change</th>
<th>Planned Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>One</td>
<td>Procedure for the effective assessment of adults and children with bladder or bowel dysfunction</td>
<td>2013</td>
</tr>
</tbody>
</table>

Named Responsible Officer:-

Continence Specialist Nurses

Approved by:

Clinical Policy and Procedure Group

Date: August 2010

Section:- Continence CP41

Impact Assessment Screening Complete

Date: July 2010

Full Impact Assessment Required Y/N

UNLESS THIS VERSION HAS BEEN TAKEN DIRECTLY FROM NHS WIRRAL WEB SITE THERE IS NO ASSURANCE THIS IS THE CORRECT VERSION
PROCEDURE FOR THE ASSESSMENT OF ADULTS AND CHILDREN WITH BLADDER OR BOWEL DYSFUNCTION

INTRODUCTION

Incontinence is common amongst individuals in the community and can in most cases be treated by members of the PHCT (Primary Health Care Team).

This procedure underpins the key principles in Good Practice and Continence Guidelines 2000. The Continence Service has a single point of access for adults with bladder dysfunction. Treatment is based on assessment and delivered in the most appropriate setting which is usually primary care.

The service offers assessments by specialists such as Specialist Nurse, Physiotherapist, Urology Nurse and Urogynaecological Nurse.

AIM

NHS Wirral is committed to providing high quality nursing services to all patients. This procedure aims to ensure those patients in the community setting who require assessment of bladder and bowel dysfunction do so in a safe and timely manner.

TARGET GROUP

This procedure applies to all clinical staff directly employed by NHS Wirral, who are required to carry out this role.

TRAINING

All health professionals required to undertake this role in their job description must have completed the two day continence in-house training three yearly to ensure skills are up-to-date.

RELATED POLICIES

Refer to relevant policies and procedures.

ASSESSMENTS

Urinary Incontinence
All patients presenting with urinary incontinence should be offered an initial assessment by a Continence Nurse in clinic or in their own home setting. This assessment includes a patient questionnaire and a nurse assessment.

Palliative
All palliative patients who require an assessment will receive this from their community nurse, further specialist advice is available from the Continence Service as required.

Bowel Dysfunction
Adults with faecal incontinence or requiring a bowel management programme are seen by the community nurse and specialist advice can be sought from the Continence Service.
### Assessment Forms to be completed:

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>International Prostate Symptom score (IPSS) questionnaire for males</td>
<td>There are individual male and female assessment forms that need completing by the health professional when assessing patients with continence problems. Both these questionnaires provide the health professional with past medical history and current information about the problems the patient may be experiencing, and treatment options. If clinically indicated, also consider</td>
<td>• 3 day frequency/volume chart N.I.C.E (2006)</td>
</tr>
<tr>
<td>International Consultation on Incontinence – short form (ICIQ-SF), for females with Urinary Incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Bowel assessment and pathway form</td>
<td>This assessment form provides the health professional with past medical history and current information about the problems the patient may be experiencing. If clinically indicated, also complete</td>
<td>• a week's chart of bowel movements (Bristol Stool) • food diary for bowel dysfunction.</td>
</tr>
</tbody>
</table>

Community nurses must also complete the Initial Community Nursing Assessment and a Comprehensive Overview to include sufficient information to lead to a working diagnosis and exclude/identify other diseases and contributory factors.

All referral forms/assessment charts are available from the continence service, also available on intranet.

All patient information leaflets are available from Wirral Integrated Continence Service

### ADDITIONAL COMPONENTS OF AN INITIAL CONTINENCE ASSESSMENT ARE:

- Agree treatment/management options with patient
- Rectal examination to exclude faecal impaction (not to be carried out in children)
- Urinalysis to exclude infection and haematuria to be directed to haematuria clinic.
- Assessment of manual dexterity
- Assessment of the environment, e.g. accessibility of toilet facilities
- Identification of conditions that may exacerbate incontinence e.g. chronic cough (Department of Health, 2000)
INITIAL TREATMENTS SHOULD BE CARRIED OUT IN A PRIMARY CARE SETTING AND CAN INCLUDE:

General advice to patients and carers about healthy living, in particular diet and drinking appropriate fluids

Implementation of a bladder retraining regime can be supported by the use of a patient information leaflet and healthy lifestyle changes.

Pelvic floor exercises: Particularly for women during and after pregnancy to prevent or cure urinary stress incontinence; also for clients with urge incontinence and for men with post prostatectomy problems. Pelvic floor and anal sphincter exercises aim to improve faecal continence

Medications such as – anti-cholinergic drugs which may reduce bladder over-activity and detrusor instability – anti-diuretic hormone for nocturnal enuresis which acts by temporarily reducing the formation of urine

Faecal impaction, constipation or faecal incontinence needs active management

The provision of pads, continence aids such as urinals, sheaths and other supplies should be considered

REASSESSMENTS

Patients on products are empowered to re-activate products and in doing so timely suggests effective management, if re-assessment is required this is picked up by the team of clinicians or requested by telephone from the patient. Patients’ who do not receive containment products needs to contact their initial assessor if reassessment required.

Palliative care patients and those with complex needs are reviewed according to their individual clinical needs.

ASSESSMENT OF CHILDREN

Assessment Forms to be completed:-

Children’s Baseline Continence Assessment
Children’s daytime wetting flow chart
Children’s daytime wetting pathway 1
Children’s Diurenal enuresis pathway
Children’s Frequency Volume leaflet
Children’s Night time wetting 1
Children’s night time wetting 2

These assessments are undertaken by health visitor teams or school nurses. Attendance at a continence assessment update is required, every three years.
The child’s Health Visitor will normally be the professional involved in the assessment of need up to the age of 4 years.

Between the ages of 5 years and 18 years the child will be assessed by the School Nurse.

When the child becomes adult and leaves school, the reassessment should then be performed by relevant health professional involved, e.g. Community nursing service, Learning Disabilities Nurse. If no other professional is involved, the Continence Service should continue to undertake reassessments.

FURTHER ADVICE AND SUPPORT

Further advice for nurses can be sought from the Continence Specialist Nurses in the Continence Service.

CAUSES AND CLASSIFICATIONS OF URINARY INCONTINENCE

Stress incontinence

Stress incontinence is caused by weak urethral sphincter mechanism, resulting in urine leakage simultaneous with a rise in intra-abdominal pressure. Contributing factors include childbirth, menopause, obesity, chronic cough and constipation. It mainly affects women, but can occur in men after prostatectomy.

Urge incontinence

An overactive bladder causes this. Urine leakage is associated with a strong desire (urgency) to void and incontinence may be sudden and large in volume. Contributing factors include urinary tract infection, type and quantity of fluid intake, medication, menopause and anxiety.

Poor Bladder Emptying

Overflow incontinence is caused by an outflow obstruction such as benign prostatic hyperplasia (BPH) or faecal impaction, an atonic or hypotonic bladder. Urine leakage is associated with overflow incontinence. Contributing factors include the side effects of some medication, constipation and sudden immobility.

Functional Incontinence

This occurs as a result of severe mobility and dexterity restrictions, which impede the client’s ability to reach the toilet unaided. It may affect those with dementia or confusion when an inappropriate response to bladder signals occurs. The client/carer should record a) the quantity and type of drinks taken, b) the volume of urine passed at each void and c) any incontinence episodes.
Urinalysis

If the urine is obviously infected or blood stained, send a clean specimen for culture and sensitivity. If urine is clear in appearance, test with reagent strip. If results are positive to either blood, protein, nitrates or leucocytes obtain a specimen and send for culture and sensitivity documenting as much information on request form.

INCIDENT REPORTING

Should any clinical incidents or near misses arise when following this procedure an Incident Form must be completed.

REFERENCES

Department of Health (2000) Good Practice in Continence Services


USEFUL RESOURCES

Contact Family Contact Line (Information Source for parent of disabled children and all professionals working with disabled children)
209-211 City Road
London
ECIV 1JN
Telephone No: 02076088700
www.cafamily.org.uk

Continence Foundation
2 Doughty Street
London WC1 2PH

Enuresis Research and Information Centre (ERIC) (Advice on nocturnal enuresis for children and teenagers, and day wetting children)
34 Old School House
Britannia Road
Kingswood
Bristol BS15 2DB
Telephone No: 0117 926 3060

Help the Aged
St James’ Walk