drh
supporting independence

CONTINENCE POLICY

1.0 INTRODUCTION

1.1. DRH recognises that:

- The potential for improvement in the quality of life that can be achieved through appropriate continence care

- As far as practicable all service users have the right to maintain or to achieve continence

- All service users who may be able to gain/regain continence should have the right to access specialist NHS Continence Services for full assessment and treatment

- Service users who are unable to gain or maintain continence should be helped to ensure safe, comfortable and dignified ways of managing their incontinence.

2.0 STANDARDS

2.1 DRH will ensure that all service users with impaired continence admitted to a DRH facility are assessed with a view to identifying appropriate causes and remedial action – or in order to introduce the most effective means of managing incontinence.

2.2 DRH recognises that there are many causes of incontinence and will seek to ensure that a comprehensive assessment is carried for anyone who lacks full bladder and bowel control.

2.3 DRH will ensure that all staff are fully informed of the role That they can play to assist service users to maximise continence.

2.4 Home Managers will ensure that support plans for individual service users address any continence problems. A detailed support plan will include specific goals to:

- Eliminate or reduce incontinence
- Maintain and optimise personal dignity and self-esteem
- Assure personal hygiene
- Maintain integrity of the service users skin

2.5 All staff will ensure that service users receive prompt and appropriate and respectful attention to enable them to access toileting facilities.

2.6 DRH will ensure that staff receive the resources and support necessary to meet these standards.

2.0 UNDERSTANDING CONTINENCE PROBLEMS

URINARY INCONTINENCE

Causes and Symptoms	Possible underlying problems	Treatment	Referral options
* Stress incontinence: leaking with coughing, laughing, exercise	Urethral sphincter incompetence, pelvic floor weakness	Pelvic floor therapy, urethral appliances, surgical intervention	Continence specialist nurse, physio-therapist, uro-gynaecologist, urologist
Voiding inefficiency, continual dribbling, weak flow, hesitancy, incomplete emptying , intermittent stream, straining to void	Bladder outlet obstruction (prostatic enlargement, urethral stricture, faecal impaction)	Clear any impaction; otherwise, surgical referral required	Prostate assessment clinic, urologist
	Muscle failure (secondary to neurological disease)	Clean intermittent catheterisation if post-micturition residual >150ml.	Continence specialist nurse, specialist continence service
Muscle overactivity, urinary urgency, frequency (>8/24h), urge incontinence, latchkey morning urgency	Idiopathic muscle overactivity	Check residual volume, advice on fluid intake, bladder retraining programme, anticholinergic drugs	Continence specialist nurse, specialist continence service
	Muscle overactivity secondary to neurological disease (eg, MS)		
	Cystitis, classical (internal) dysuria secondary to UTI	Appropriate antibiotic therapy. Refer if recurrent	Urologist, urogynaecologist, continence specialist nurse
	Atrophic urethritis or vaginitis, external dysuria	Topical oestrogen replacement or systemic HRT	Gynaecologist, specialist continence service
	Bladder calculus	Surgical referral	Urologist
Cognitive impairment	CNS disease (dementia, delirium)	Exclude iatrogenic causes; appropriate toiletting	Community nurse, community psychiatric nurse, specialist continence service

	Developmental disability	programme; minimise handicap	
Physical impairment	Impaired dexterity/mobility		Physiotherapist, occupational therapist
Enuresis - bed-wetting	Detrusor instability, prostatism, immobility, primary nocturnal enuresis	As for underlying condition. Antidiuretic in some cases.	Specialist continence service
Psychoemotional & behavioural	Apathy Boredom Depression Anxiety and fear Functional – reinforced by consequences	Address underlying Causal or contributory factors	Behavioral management specialist
Environmental	Inadequate toilet facilities Badly sited toilet facilities Poorly signed toilet facilities Inadequate staff support Lack of privacy	Address underlying Causal or contributory factors	

Possible confounding factors: anticholinergics, diuretics, alpha adrenoreceptor blockers, calcium channel blockers, sedatives

Always review environment, e.g. ease of access to WC

Containment during investigation or if problem regarded as intractable:

- body worn and bed pads
- urethral appliances
- timed voiding programmes
- sheaths and urinals
- indwelling catheter (last resort)*****

FAECAL INCONTINENCE

CAUSES

There are several causes of faecal incontinence. Some are more common than others and some causes may demand urgent medical attention.

Muscle Weakness

Weakness of anal muscles or sphincter may result in leakage of stool. Typical causes of such weakness include:-

- childbirth;
- some types of surgery - for example, for haemorrhoids (piles).

Severe Diarrhoea

This may be intermittent or constant depending upon the cause. Common causes include:

- infection - the most common cause;
- side-effects of some medicines, such as antibiotics;
- some specific (and relatively uncommon) diseases, in particular colorectal disease, ulcerative colitis, Crohn's disease and diverticular disease;
- reduced absorption of liquids from the bowel, which in some cases is the result of surgery;
- radiotherapy;
- irritable bowel syndrome (IBS).

Constipation and Impaction

This is probably the most common cause among older and disabled people. With constipation, especially when the faeces become extremely hard or "impacted", the body tries to soften the stool by adding liquid to it. This can result in a type of diarrhoea, known as "spurious diarrhoea", which is characteristically orange or light brown in colour. Faecal incontinence of this type is characterised by periods of no bowel movement followed by a few days of incontinence.

A number of factors can contribute to constipation. These include:-

- poor diet - low in fibre;
- poor fluid intake;
- poor mobility;
- some medicines - for example, some pain killers.

Disorders of the Nervous System

Incontinence can sometimes be the result of disease or injury to the nerves. This may result in:

- a lack of sensation so that you do not feel the need to empty your bowel. This can be either because the nerves in the bowel do not send the normal

signal to the brain or because the central nervous system does not process the signal to make you aware of the situation;

• loss of nerve input to keep the sphincter muscles contracted and so keep the anus closed.

The following neuropathic disorders can sometimes cause incontinence:-

• spina bifida;
• spinal injury;
• multiple sclerosis;
• stroke;
• dementia.

3.0 MAINTAINING A SAFE & HEALTHY ENVIRONMENT

3.1 Urine spillages should be cleared up immediately using the correct materials and equipment provided for the purpose. If any malodour persists the Home Manager should seek advice regarding further remedial action from the Homes' Liaison Officer

3.2 Each DRH facility will have agreed procedures for the disposal/laundering of soiled disposable pads; bed-linen and clothing. Home Managers will ensure hat all staff comply with these procedures.

4.0 REFERENCES

i) Good Practice in Continence Services: Department of Health

ii) Continence – adults with urinary dysfunction. Best Practice Statement NMPDU NHS Scotland

iii) Continence Foundation (2000): Continence Resource Pack. Continence Foundation, London.

SG 1998
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