Shropshire Community Health NHS Trust

Standing Operating Procedure for requesting continence products

Purpose

Document Details		
Title	**Requesting continence products- community.**	
Trust Ref No	2257-86521	
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Approval process		
Approved by (Committee/Director)	Clinical Policies Group	
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No	Date	Amendment
1	16-08-2021	SOP initiated. Active from 01-09-2021
2	25-03-2022	Reassessment Process added.
3	27-07-2022	Buffer stock information added.
4	30-12-2022	Reassessment process updated.
5	21/12/2023	Community Hospital assessment criteria.

This has been written in order to formalise the process of requesting continence products. This is to ensure all continence assessors are completing the required documentation before requesting any continence products. All Nurses, Assistant Practitioners (AP's) and Nursing Associates (NA's) must have attended the Bladder and Bowel training provided by the trust before undertaking an assessment and they must be on the assessor's database. The Nurses, AP's and NA's must undertake the assessment themselves due to accountability and they must not countersign assessments undertaken by untrained staff members.

Introduction

This guidance aims to ensure that all patients receive the optimal level of clinical care in line with best practice and research regarding assessment of bladder, bowel and continence issues and management on incontinence including the provision of containment products.

Scope

The SOP applies to anyone who is assessing a patient for continence products. If the patient who is being assessed is within the last 6 weeks of life and is receiving end of life care at home- this does not apply, and a product request form can be sent directly to HDS- the assessor must state the patient is within the last 6 weeks of life and they must use their clinical judgement to assess if the order is for urgent delivery. Justification for this must be written on the assessor ordering form CONT036.

Definitions

HDS Home Delivery Service
EOL End of Life
IDT INTERDICIPLINARY TEAM
SPR Single Point of Referral
HCP Health Care Professional

Responsibilities

Caseload holders must ensure that their staff are given the appropriate time to complete the RiO continence assessment- 50 minutes.
Continence assessors must send out relevant pre-assessment documentation before arranging the continence assessment, this includes a symptom profile, bladder diary and a bowel diary if appropriate. If the patient is unable to complete this, justification must be written within the RiO continence assessment.
The continence service must provide support and assistance to the community teams. Email advice can be requested by emailing shropcom.continence@nhs.net or they can be phoned on 01743444062.
All staff completing a continence assessment must have completed the bladder and bowel assessment training provided by the trust. If staffs feel they need an update, they must book onto the training provided by the trust.
The 'Policy for Assessment and Provision of Continence Products' must be followed at all times and if patients do not meet the criteria for product provision, they must be discussed with the continence service.
All staff must provide honest information.

Procedure

1. **Patient identified as incontinent.**
2. **Continence assessment arranged and pre assessment documentation sent out for the patient/carer to complete (Symptom profile/ bladder diary/ bowel diary if appropriate)**
3. **If patient is suitable to attend the continence advisor service clinic for active treatment, not management of products, please refer by writing a letter to shropcom.continencereferrals@nhs.net**
4. **Complete the District Nurse continence assessment form on RiO which can be found in adult global. Please note, from 01-09-21, if this form is not completed for a new patient assessment, your product request form will be**

returned by HDS and your request will not be considered (unless this is an EOL patient in the last 6 weeks of life). Please ensure all aspects of this form are completed- including your rationale for not requesting alterative management devices such as urinary sheaths/ urinals/ washables etc.

5. Please fully complete a CONT036 Assessor ordering form and email this to shropcom.continencedatabase@nhs.net Please make sure all of your contact details are completed, including the name of the assessor who completed the assessment as the form may be returned or the Contienence advisory service may need to contact you to discuss the request.
6. Please arrange a continence re-assessment for 6 months after the initial assessment- the reassessments are now live on RiO and can be found in adult global.
7. Assessor must state clearly on the order form if the patient is EOL, this is so the HDS team can process the request as soon as it is received.

Monitoring

The procedure will be monitored by the Home delivery service and if the appropriate documentation is not completed, the assessors order form will be returned to the assessor.
If off formulary requests are made or the amount of products requested is below/above policy, the continence advisors will expect justification to be written within the continence assessment. If this justification is not made, the request will not be approved and further information will be sought from the assessor. This could delay the patients receiving their products and you may need to reassess the patient.
Please consider the continence policy when assessing a patient.
Please reassess patients wearing pull ups every 6 months and provide written evidence of 6 monthly reassessment.
The HDS will be checking every patient has a RiO continence assessment and/or RiO continence reassessment documented if required. If they do not have one evidenced, then the request for products will be returned to the sender. This includes patients that require a new assessment, a change to their current provision and for 6 monthly pull up reviews.

Patient to be sent a letter from the Home Delivery Service (HDS) outlining the process for reordering further products and also who to call if they are experiencing problems with their products.

Reassessment Process:

Following initial assessment, Patient is aware that they will need to phone 01952580400 to re-order their products or if they feel the products are not meeting their need.

For routine reassessments- patient calls to reorder products every 10-12 weeks. The patient or patient carer phoning will be asked 'Do your products remain

effective'. If the patient says yes, a delivery date will be arranged, and the products will continue to be supplied (NB this does not include pull up pads).

If the patient says No, a supply of products will be delivered as per the prescription, to allow time for a referral to be made to the IDT team for a full reassessment via RIO. The HDS team will then refer this patient to the IDT via SPR and a new referral will be generated, the IDT will then arrange for this to be done in a timely fashion bearing in mind the referral to treatment time. Following this order, HDS will put a hold on any further orders until the reassessment on RiO has been completed and a new Product order form emailed over to shropcom.continencedatabase@nhs.net When the reassessment process is complete, the patient can be discharged from the IDT caseload, unless they have an open referral.

For those patients with an open referral to the IDT, HDS will contact the teams directly to prompt a reassessment at the next visit. Ultimately, if these patients are being visited regularly, they should be undergoing a holistic assessment at each visit 'making every contact count' and any problems with their product provision, should be picked up during the visit and then actioned.

If the patient is phoning less frequently to order, HDS to ask the patient the reason they have not ordered every 12 weeks HDS team to assess if the reason provided is justifiable, however, if this happens on a consecutive cycle of 2 orders, HDS team to discuss with the continence service. If the patient feels they have received too many products- the order will be placed on hold and a referral to the IDT will be made via SPR. If the patient provides a reasonable explanation, HDS must discuss this with the continence service and the continence service will make the decision as to whether the reason is acceptable. The continence service will communicate this to HDS staff and feedback if they feel a reassessment in necessary.

Washable products.

If you assess your patient as suitable for washable products, please complete the same process around initial assessment and reassessment (using the RiO assessment documentation and following the questions/instructions related to washable products).

Patient will continue to receive their products on a 12 monthly cycle if they continue to order and patients will receive a letter with their first order, prompting them to contact HDS if their products are no longer suitable. This will then instigate a new reassessment. Examples of the product being unsuitable will be listed within the content of the letter for both washable and disposable products.

Buffer Stock

Buffer stock is for palliative care and emergencies only.
All buffer stock orders will be sent to shropcom.continencedatabase@nhs.net for authorisation. A shaped product ID form extra and id form normal will be provided.
Patients should be assessed as soon as possible, and an order placed with the HDS.

Community Hospital Assessment criteria

When a continence assessment has been carried out on a Community Hospital Ward, a RiO continence assessment form must have been completed and a product order form sent through to shropcom.continencedatabase@nhs.net This is to ensure equity of assessment across all Trust services. This will also provide the continence service with the information they require, should they need to approve an off-formulary request. Any HCP band 4 and above undertaking a continence assessment, must have completed the Trust Bladder and Bowel training or their assessment will be refused.

References

Detail any relevant internal or external references

Forms/templates

CONT036- Microsoft Word - CONT 036- Product Ordering form_06.04.21 (1) (1).docx (shropscommunityhealth.nhs.uk)

Bladder diary- Microsoft Word - CONT 023 Bladder Diary.doc (shropscommunityhealth.nhs.uk)

Bowel diary- Microsoft Word - CONT 027 Bowel Diary.doc (shropscommunityhealth.nhs.uk)

Symptom profile- Microsoft Word - CONT 040 Symptom Profile.doc (shropscommunityhealth.nhs.uk)

Step by Step guide to completing the RiO Continence assessment form. V1 08/06/21

To find the form on RiO, search patient ➡ Forms ➡ Adult Global

Complete the date, time and consent.

Presenting symptoms.

Please use this text box to describe the symptoms the patient presents with that have prompted this assessment.

Surgical History.

Click yes or No, and if Yes to any, type further information below in the text box such as date/year the surgery was performed.

Obstetric History.

Complete if female.

Medication History.

Please tick if your patient is taking any of the listed medication types and provide any further information in the text box provided. Please also document the efficacy of any of these medications if they have been taken in the past and if possible provide the amount of time the medications were taken.

Patient Assessment.

A bladder diary should always be requested before a continence assessment. Please upload a copy of this using the link provided. If the patient cannot complete a bladder diary, please state why in the text box provided. Please summarise the fluid intake as prompted in the text box.

At this stage, please consider the fluid type i.e. is the patient drinking predominantly caffeinated drinks which is exacerbating their symptoms.

What colour is the patients urine? Please use the link to the ‘Are you drinking enough’ chart and patient leaflet. Consider possible dehydration or excessive drinking.

Has urinalysis been completed?

Please note, this is not to check for a UTI, this is to identify any other possible abnormalities and red flags such as blood in the urine which may require further investigation by the GP. If the patient is symptomatic of a UTI, please use the link to the UTI assessment form and follow the instructions on the form.

How often does the patient pass urine in 24 hours?

Please use the bladder diary to work this out unless the patient is fully incontinent or has an indwelling catheter. Please document this if so.

Exacerbating Conditions.

Complete as appropriate answering Yes or No.

Vaginal/ rectal examination.

Complete as appropriate.

Bladder function.

Male- If the male patient has had a confirmed UTI in the last 12 months, a bladder scan must be arranged to rule out chronic retention.

Female- If a female patient has had 3 confirmed UTI's in the last 12 months, a bladder scan must be arranged to rule out chronic retention.

Symptom profile- please upload a copy of this completed document. Please use the symptom profile to identify the main symptom. If the main symptom is stress incontinence, please consider a programme of pelvic floor exercises (leaflets to support this are available on the continence website. Alternatively refer the patients onto the continence service if they are able to attend the clinical setting)

Please use the box provided to document the outcome of the bladder scan.

Bowel Function.

Complete as prompted.

If any red flags have been identified, please refer the patient to their GP and document that this has been done.

Assessment Summary.

Please use this text box to summarise the assessment so far and to document any additional information that the patient has told you.

Management of incontinence.

Complete as prompted.

Appliances/ aids

Please use this list of aids as a reminder that disposable continence pads are not the only option in managing incontinence. Please justify below why none of the aids are appropriate and/or if you have trialled any of them.

Washable products.

Follow prompts.

Disposable products.

Please justify your reason for choosing disposable products.

Please arrange for a sample of the products to be trialled via ontex.samples@nhs.net
Please follow the prompts on the form and ensure justification has been documented if off formulary/ off policy products have been requested. Failure to provide this information will delay the patients receiving their products and the product request form will be returned to the assessing HCP.

Follow up.

Please follow the prompts and arrange a reassessment in 6 months time.