Guidance for the provision of absorbent products for adult incontinence

A consensus document
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Association for Continence Professionals

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Document Purpose	Guidance/Policy
Document name	Guidance for the provision of absorbent products for adult incontinence: A consensus document
Publication date	2017
Target Audience	Commissioning Leads, Foundation Trust Chief Executives (CEs) Directors of Nursing, Local Authority CEs, NHS Trust Boards, Allied Health Professionals, GPs, Consultants, Directors of Nursing; NHS Trust CEs, Bladder & Bowel Service Leads, Care Homes, Procurement Matrons, acute and community settings and members of the public
Additional Circulation List	Bladder and Bowel Service Leads across England (although other countries may find the document useful)
Description	Consensus document regarding the provision of continence absorbent products for adults, to ensure all adults who suffer with urinary or faecal incontinence, undergo a comprehensive assessment, and have access to an equitable service
Cross reference	Excellence in Continence Care (NHS England 2015) Minimum Standards for Continence Care (2021) https://www.bbuk.org.uk/wp-content/uploads/2021/11/Guidance-for-the-provision-of-continence-containment-products-to-children-2021-2.pdf
Superseded documents	N/A
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Document host	Association for Continence Professionals (ACP) This publication contains information, advice and guidance to help continence services. It is intended for use within England but may help service other countries. However, readers are advised that practices may vary in each country and outside the UK. The information in this booklet has been compiled from professional sources, but its accuracy is not guaranteed. While every effort has been made to ensure that the publication provides accurate and expert information and guidance, it is impossible to predict all the circumstances in which it may be used. Accordingly, the ACP, Royal College of Nursing (RCN) and United Kingdom Continence Society (UKCS) shall not be liable to any person or entity with respect to any loss or damage caused or alleged to be caused directly or indirectly by what is contained in or left out of this information and guidance. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means electronic, mechanical, photocopying, recording or otherwise, without prior permission of the authors. This publication may not be lent, sold, hired out or otherwise disposed of by ways of trade in any form of binding or cover other than that in which it is published, without the prior consent of the authors.

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1. Purpose

An absorbent incontinence product is the *'most commonly used product for absorbing and containing both light and moderate/heavy leakage'* (Continence Product Advisor 2017). The incontinence product is classified as a medical device (MHRA 2014) and therefore safety and fitness for purpose is fundamental in achieving quality care. This document focuses on the provision of products for adults (men and women) across England; however, other countries may also find it useful.

Best practice is where clinical assessment and personalised care planning is a fundamental activity prior to any provision of product, from the age of 18 years old. It is everyone's business to identify and provide initial help to those with continence issues and not just those who work and specialise in bladder and bowel services. Transition for the child/young person to adult continence care must be underpinned by both the Child and Young Person consensus document (Bladder & Bowel UK 2021) and this document. The transition process needs to be robust and in conjunction with the local children's bladder/bowel (continence) service as described by the National Institute for Health and Care Excellence (NICE) https://www.nice.org.uk/guidance/ng43.

The document was produced through a consensus approach predominantly via membership of the Association for Continence Professionals (ACP) and is applicable to all clinical settings. Any conflicts of interests were managed, and agreement reached via discussion.

Within England, although national guidance does exist (DH 2000), there is no statutory requirement for the provision of products for incontinence, resulting in each health care trust and integrated care systems developing their own policy and guidelines. Consequently, the variation and discrepancy in access to provision has resulted in lack of equal access to care and disproportionate distractions from best clinical practice. Clinical assessment is a critical component in the diagnosis of the underlying causes of incontinence, which must identify opportunities for treatment, before considering containment with products.

1.1 Accountability

The clinician who assesses an individual to provide an absorbent product is accountable for that decision; and needs to ensure that the chosen product is fit for purpose and safe to use at the time of assessment (in accordance with MRHA 2014). There is a responsibility for the patient and/or carer to request a reassessment if their needs change. Where risk to safety or harm exists, it is recommended to seek advice from the multi-disciplinary team or continence service. The patient or carer must be advised on how to apply/use the product and be given sufficient information and training in the safe use of the product.

The clinician must also ensure the clinical assessment for a suitable absorbent product takes account of the environment(s); and ensuring Covid-19 safety (https://www.nhs.uk/conditions/coronavirus-covid-19/). For example, the assessment must consider what would be suitable if the patient is soon to be transferring between care settings from areas of high carer support to lower levels of carer support (such as on discharge from a hospital or nursing care setting to their own home or supported living), or in their own home. The rationale is that a product that may be deemed suitable in a facility where there is 24-hour nursing or carer support may not be suitable to meet the needs of that patient in the environment of their own home, where they may have little or no support.

2. Background

People have the right to receive the right treatment at the right time and live the best achievable quality of life possible (NHSE 2018). The Francis Report (DH 2010) highlighted poor patient experience in bladder and bowel continence care, which gave the 'impression of continuous neglect'. Of 33 cases heard during the enquiry, there were significant concerns for 22 of the cases, most notably:

- Poor response to patients requesting assistance
- Patients being left in soiled sheets
- Patients being left on commodes
- Uncaring and unsympathetic attitude of staff

Dignity and quality care is at the heart of continence care provision. Skilled and trained staff across health and social care communities are fundamental to delivering this (Rantell et al 2016).

3. Current issues

Bladder and bowel problems are common and, in most cases, treatable, but they are poorly understood and under-prioritised within health and care provision in England (RCP 2010; Orrell et al 2013). Estimates of the burden of incontinence in England suggest that it affects up to 14 million people (NHSE 2018).

Although the risk of incontinence increases with age and is a reason for care home admission (Schluter et al 2017), symptoms affect every section of the population, across all stages of life, including children, people with a learning disability or other chronic condition as well as otherwise healthy adults.

Incontinence is a symptom, not a disease or diagnosis and has many possible causes as well as being only one of a range of other bladder or bowel symptoms. Urinary and faecal incontinence has been defined as 'the complaint of any involuntary leakage of urine or faeces' (Abrams et al 2002). Treatments are varied and it is therefore important to diagnose the cause(s) accurately. There is an increasing body of knowledge about the clinically effective treatments for most types of faecal and urinary incontinence, particularly through clinical guidance and quality

standards, such as NICE and the Scottish Intercollegiate Guideline Network (SIGN) (NICE 2007, 2008, 2010, 2012, 2013, 2014, 2015, 2016 and 2017; SIGN 2012).

The impact of moderate symptoms on quality of life has been found to be like that of diabetes or high blood pressure, affecting a person's independence, their productivity, sleep and mental wellbeing; and increasing social isolation (Yip et al 2013). The lack of timely access to high quality assessment, care, treatment, and support in England has been well-documented over time, for example the All-Party Parliamentary Group (APPG) for Bladder and Bowel Continence Care; NHS England (NHSE) and the British Geriatrics Society (BGS) (APPG 2011; NHSE 2018; BGS 2016). Poor continence care is not only distressing and degrading for individuals, but it also contributes to unnecessary costs to the NHS through avoidable complications such as infections, pressure ulcers and falls, which can increase the amount of time spent in high-cost hospital settings as detailed by the Expert Group on Lower Urinary Tracy Symptoms (Expert Group on LUTS 2014).

There is no question that demand for bladder and bowel services is, and will continue to be, compounded by the changing demographics of the population of England. Furthermore, the increasing pressure on related statutory services, improved techniques in neonatal diagnosis and early year's intervention in health care, an ageing population and better management of chronic conditions. Effective community-based continence services can save valuable NHS resources whilst restoring dignity to people and improving quality of life (NHSE 2018).

Previous national guidance advised that commissioners should move towards direct provision of absorbent products for nursing home residents and that reimbursement arrangements only continue on an interim basis (NHS 2009). Unfortunately, this hasn't been implemented for many homes across England (Care England 2013).

Continence care requires a higher priority than it currently receives, as improving provision through better integration can improve outcomes and provide a better quality of life for individuals and their families, and increased independence through finding solutions appropriate to individual needs. For example:

3.1 Use of containment products and intervention

- Treatment of incontinence will reduce reliance on products and products as currently the number of individuals requiring a product is increasing year on year (Wagg et al 2008; Murphy et al 2018).
- Providing and procuring in line with the procurement strategy, facilitating a cost-effective approach to purchasing continence products (NHSE 2016).
- Treating overactive bladder syndrome in women produces Quality Adjusted Life Years (QALY's) gains and can reduce reliance upon containment products (Phillips et al 2015).
- Low-cost community interventions e.g., lifestyle interventions, can cut product usage by 50% (Imamura M et al 2010)
- Cost of pelvic floor interventions and bladder retraining is offset by a reduction in product usage (Demaagd and Davenport 2012; Borrie 2002)

- The multiprofessional approach to care must involve Occupational Therapy, Physiotherapy, and other disciplines (such as Learning Disability or Mental Health Nurses) as required, as this can support individualised toileting programmes, support patients with functional incontinence and help to reduce reliance on and costs of high absorbency containment products (Spencer et al 2017).
- Providing a mixture of devices and products is preferred by users and reduces the number of products used (Macaulay et al, 2014)

3.2 Infections

- Reducing the use of indwelling catheters can help to reduce catheter associated urinary tract infections (CAUTI'S) in combination with evaluation, education, and training (NICE 2012; RCN 2018; Slyne et al 2012).
- Pressure ulcers and incontinence associated dermatitis is a national priority and identifying, assessing and treating continence issues can significantly reduce skin problems http://nhs.stopthepressure.co.uk/
- Urinary tract infections is a common clinical entity in primary and secondary care https://www.gov.uk/government/publications/urinary-tract-infection-diagnosis
- Optimum symptom management can help to reduce infections (Shaw and Wagg 2017).

3.3 General Population and Care Home admission

- Incontinence is a significant factor for admission to hospitals and care homes (Leung and Schnelle 2008)
- 50% of care home (with nursing) residents have faecal incontinence which can be a treatable condition (Leung and Schnelle 2008)
- Three quarters (73%) of hospital admissions for constipation are emergency admissions as reported via Hospital Episode Statistics (HES) data (HES 2012)

However, not all costs are financial. There is a large body of evidence about the effect of continence problems not just on the system, but on people's lives. There can be considerable psychological impact, affecting confidence, achievement and integration into society, personal relationships, body image and intimacy.

4 Best practice statements for the provision of products

This guidance assumes that clinical assessment and first-line treatment has taken place, and the patient has a clinical need for absorbent product provision. Clinical need can be defined as 'a process by which information is gathered regarding the scope and potential impact of gaps or deficiencies in the current delivery and practice of health care' (Weigl et al 2012).

4.1 All care settings

1. Men and women must be treated equally in relation to absorbencies, anatomical shape, and product range available.

2. All adults with an identified continence problem must be offered a comprehensive bladder and/or bowel clinical assessment of their continence condition within locally agreed referral to treatment times. A positive response to the trigger question, *"Does your bladder or bowel ever/sometimes cause you problems?"* must lead to a comprehensive clinical bladder and or bowel continence assessment.

3. For adults where it is known or anticipated there may be difficulties with maintaining bladder and/or bowel health e.g., learning disabilities, dementia, frailty, or degenerative neurological conditions they must still have the opportunity for treatment before containment management options are implemented.

4. The registered healthcare professional remains responsible for the patients in their care; and for the clinical assessment of continence and instigation of first line treatment. The undertaking of a continence assessment can only be delegated to a non-registered healthcare professional who can demonstrate the necessary theoretical knowledge, skills, and expertise, from Band 4 (Foundation Degree level e.g., Assistant Practitioner or Nurse Associate) upwards. Clear lines of accountability, responsibility and supervision by the registered healthcare professional who delegated the task must be in place.

5. Reassessment of bladder and bowel health; and product provision must be undertaken annually as a minimum. Patients must be encouraged to co-operate with reassessment and should they choose not to make themselves available or decline reassessment, then product provision via the NHS will be suspended or cease.

6. Individuals must be encouraged to self-fund absorbent products until a clinical assessment has taken place. However, clinical assessment timescales (within referral to treatment time targets e.g., 18 weeks) must align with local commissioning arrangements.

7. Individuals (and healthcare professionals) could be encouraged to use the evidence-based and independent Continence Product Advisor website for product advice (www.continenceproductadvisor.org). This includes a validated patient decision aid to enable self-purchase/prescription of products and devices most suited to their needs.

8. Absorbent products should not be supplied for treatable medical conditions (or for bodily fluids other than urine or faeces). The ‘custom and practice’ of automatically providing products to adults (including those with an acknowledged

disability) is not appropriate and could be considered discriminatory. If an individual has capacity and declines treatment, provision of products will not be offered as an alternative (an exception will be end of life).

9. Alternative collection devices must be considered for example, prescription urinals, urinary sheaths and body worn urinals, bags, and adaptive underwear (e.g., specialist briefs with adapted collection systems).

10. The number of absorbent products issued per 24 hours must meet assessed clinical need, although some localities apply restrictions. As part of the continence assessment process a validated scoring system might be used to objectively measure "clinical need" in continence care. Products must be provided to meet patients' fundamental care needs, including maintaining independence (Murphy et al 2019).

11. Washable continence containment products must be available via the NHS for urinary incontinence.

12. If clinically appropriate, items are also available on prescription such as urinary sheaths, body worn appliances or anal plugs.

13. Small lower absorbency disposable products are available from a variety of sources for self-purchase, especially where the volume of urinary incontinence is low, and treatment is expected to be effective.

14. Use of a patient decision-aid (Murphy et al, 2020), which is specific to men post-radical prostatectomy, will help to identify products and devices that can be used along-side absorbent products. A decision-aid is incorporated into the continenceproductadvisor.org website, which may help.

15. Evaluation of the comparative effectiveness and acceptability of absorbent products should be made using a validated tool. The ProductProm (Yearwood-Martin et al 2018) is an example of a tool and is part of the International Consultation on Incontinence suite of patient reported outcomes https://iciq.net/iciq-productprom

16. Where an individual presents with faecal loss only, the super absorbent powder included in body of product is not necessary. However, careful selection of product is essential in discussion with the individual.

17. A holistic clinical assessment will guide the selection of the appropriate product style including absorbency and fitting style (Appendix1). Fader et al (2008) indicate a range should be available to include two-piece, wraparound, belted and pull ups.

18. Individuals in receipt of absorbent products should take enough supply when going on holiday or anticipated periods of time away from home (e.g., hospital admission).

19. Exceptions (e.g., not registered with a General Practice or clinical need beyond local guidance/policy) must be subject to a robust process to ensure equity of care.

20. Transition of children/young people into adult services must be cognisant of the need for continuation of continence care. Reassessment of clinical need (not just historic provision) must be conducted within six-months of transition and thereafter annually.

21. Transfers between service areas – if products or quantity differs and the patient has not had an updated clinical assessment within the last 6 months (that can be made available to the specialist bladder and bowel service in the area the patient has moved to), the patient will have to undergo a new clinical assessment; adhering to local provision until such time as an "exception/ outside of policy/above policy" case is made to the local commissioner for consideration.

22. Product costs and quality data are commercially sensitive and should be available on a confidential need to know basis to the Local Commissioning Board and GP's when assessing or planning services to meet the overall health needs of their population.

4.2 Acute hospital inpatient care, Community Hospitals and Community Settings

23. Where an elective surgical procedure is anticipated; and it carries the potential risk of incontinence post operatively, the healthcare professional who is managing their care must consult with or refer the individual to the specialist bladder and bowel services prior to the operation (e.g., prostate surgery).

24. Absorbent products will not be supplied before the individual person has undergone a comprehensive clinical assessment. Exceptions to this are for individuals at the end of life or for unplanned inpatient hospital admissions during the period of an acute illness, where a comprehensive clinical assessment is not possible. However, an assessment must be undertaken once an acute episode has stabilised. Assessment must be undertaken prior to discharge if incontinence is unresolved. Discharge from hospital must not be delayed for the patient with identified continence needs; an assessment must be made a priority issue prior to discharge.

25. During their hospital stay, all individuals with incontinence must have a clinical assessment or reassessment completed and any first line treatment initiated (Table 1). Where a clinical assessment has previously been performed, this information must be transferrable between settings and reviewed accordingly through partnership working. In unresolved incontinence or in more complex cases, referral should be made to inpatient continence services if available. If incontinence has not resolved prior to discharge home, the hospital team must refer the patient for further clinical assessment on their return home. The hospital must have a robust discharge process in place to ensure individuals are

assessed by an accountable healthcare professional (refer to accountability in sections 1.1 and 4.1.4). An interim product supply must continue until reassessed in the community setting, to ensure that the patient is not placed at immediate risk. For those who can, individuals may wish to self-fund supplementary products until a community continence assessment has taken place, which can be as long as 8 to 12 weeks. If unable to self-purchase, priority may need to be given.

Table 1

Product provision advice	**Pre-existing incontinence**	**New-onset incontinence**
Elective admission	Supply of products to be brought in from home Reassessment of continence, bladder and bowel dysfunction and instigation of first line treatments, in line with national guidance/Trust policy	Assessment of continence, bladder and bowel dysfunction and instigation of first line treatments, in line with national guidance/Trust policy Liaise with specialist bladder & bowel services if clinically indicated
Unplanned admission	Hospital provision of product, where possible supply of products to be brought in from home Reassessment of continence, bladder and bowel dysfunction and instigation of first line treatments, in line with national guidance/Trust policy	Assessment of continence, bladder and bowel dysfunction and instigation of first line treatments, in line with national guidance/Trust policy Liaise with specialist bladder & bowel services if clinically indicated

26. Inpatient services must have a locally agreed incontinence product formulary, which is adhered to and to avoid undue confusion for patients and carers, aligns with the local community formulary. If clinical assessment identifies a need outside the formulary advice must be sought from the specialist continence service.

4.3 Care Homes (Nursing & Residential)

27. All care home residents, both nursing and residential (regardless of funding arrangements) must receive assessment, treatment, and products via the same NHS system to ensure quality and equity. Financial reimbursements are not recommended and where this exists, the move to a provision system must be raised and managed between the local commissioner and the bladder and bowel service providers.

28. Care homes where residents are in receipt of absorbent products via the NHS must co-operate with periodic audit by the NHS product provider to ensure efficient use of NHS funded products and resident's clinical needs are met. Furthermore, care home managers must identify any staff training needs that may be required to support product use

29. When a local commissioner provides funding for a person who requires residential care outside of their boundary that local commissioner will be responsible for the cost of any absorbent products that maybe required by that person.

5. Recommendations

The following recommendations are aspirations, which aim to be woven into national policy and guidance decisions as and when the opportunity occurs:

- Develop a standardised clinical assessment electronic template and scoring system to provide equitable access across the UK.

- Design and develop innovative models of integrated continence care delivery to ensure patients do not continue to fall between the gaps of care sectors. Thus, reducing the risk of falls, readmission, tissue viability issues and psychosocial distress.

- National non-branded patient information leaflet regarding NHS absorbent product provision, with space so details of local continence services can be added.

- Public support networks - increased co-operation between NHS and voluntary sector to offer wider public support networks via independent charitable organisations such as Bladder & Bowel UK, and Age UK, etc.

- Options for absorbent products to be incorporated within the personal budget system.

- Improved Care Quality Commission inspection of the quality of clinical assessment and treatments across all care settings.

- Audit information from Home Delivery data collection and reporting systems must facilitate comparisons and benchmarking at national level.

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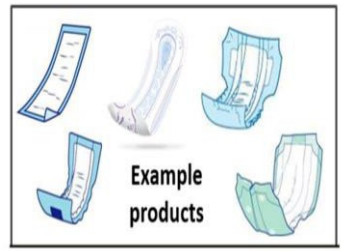
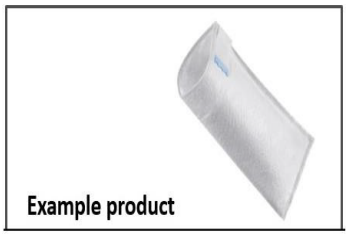
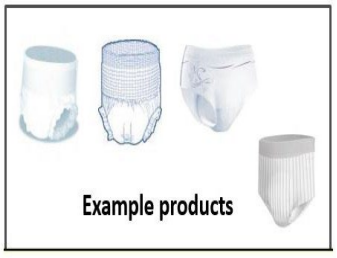
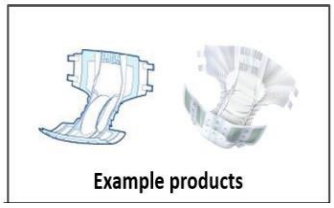
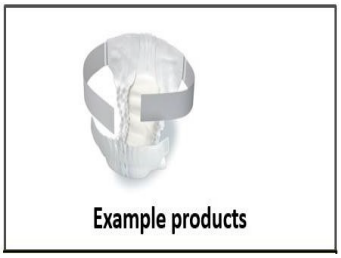
Appendix 1

New terminology for single use bodyworn absorbent incontinence products

Category 1	Product - a waterproof-backed absorbent product that is held in place using separate, close-fitting (regular or specially designed) underwear.	
Category 2	Unbacked product - an absorbent product without a waterproof backing used either inside another product or on its own, secured using separate, close-fitting, underwear which itself includes waterproofing in the product area.	
Category 3	Male product - a waterproof-backed absorbent product for men that is designed to cover the penis and scrotum, and is held in place using separate, close-fitting (regular or specially designed) underwear.	
Category 4	Male Pouch - a waterproof-backed absorbent product for men, fashioned into a pocket into which the penis – and sometimes the scrotum, too – is placed	
Category 5	Pull-on product (Protective underwear) - a product in which the absorbent core, waterproof backing and the means to hold it in place are combined in a single design resembling regular underwear. Elastic linings around the waist and hips help give a close fit.	

Category 6	Wrap-around product (All-in-one, Adult brief) – a one-piece product in which the absorbent core and the means to hold it in place are combined in a single design, secured using adjustable adhesive tabs or a hook and loop fastening system at the sides.	 Example products
Category 7	Belted product or belted product - a one-piece product in which the absorbent core, waterproof backing, and the means to hold it in place are combined in a single design, secured by means of an adjustable belt with adhesive tabs or a hook and loop fastening system.	 Example products

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