Nottinghamshire Healthcare NHS
NHS Foundation Trust

Mansfield and Ashfield Clinical Commissioning Group

Sherwood Forest Hospitals NHS Foundation Trust

Nottinghamshire Care Association
Representing care homes in Nottinghamshire and the City of Nottingham

Policy: The Assessment, Treatment and Management of BLADDER PROBLEMS & URINARY INCONTINENCE in Adults across all health sectors in Mid-Trent

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Disclaimer

- **Overarching policy statements must be adhered to in practice.**
- **Clinical guidelines are for guidance only. The interpretation and application of them remains the responsibility of the individual clinician. If in doubt contact a senior colleague or expert.**
- **The Author of this clinical document has ultimate responsibility for the information within it.**
- **This clinical document is not controlled once printed. Please refer to the most up-to-date version on the intranet.**
- **Caution is advised when using clinical documents once the review date has passed.**

Appendices have either been published separately to the SFH intranet site alongside this policy and hyperlinked back to the policy or attached to the end of the policy and bookmarked. For 'externally sourced' documents such as many of the NHC leaflets and the APC guideline, links are provided directly to the documents.

It is the responsibility of the Specialist Continence Services NHC to ensure the most up to date versions of their leaflets are available.

It is the responsibility of the Locality Support and Development Manager (M&A CCG) to ensure the most up to date version of their document (App 12a) is provided for SFH intranet administration.

It is the responsibility of the Consultant Geriatrician (lead policy author, SFH) to ensure any changes to App 16 are highlighted and communicated.

It is the responsibility of the Consultant Geriatrician (lead policy author, SFH) to provide NHC and M&A CCG with the final approved version of the policy and most up to date SFH appendices.

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Appendix 1	Adult Patient Identified with Continence Problem Pathway	**NHC ONLY**	NHC
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1. INTRODUCTION

Urinary incontinence (UI) is common affecting women and men (to a somewhat lesser extent) of all ages. The problem becomes more prevalent with greater age. It can seriously affect physical, psychological and social well-being, the impact on families and carers may be profound. The estimated cost to the NHS is currently £233 million per year. An estimated 4 million women over the age of 40 are regularly incontinent in the UK. A MORI poll reported in 1993 the prevalence of urinary incontinence in the community (4007 community dwelling adults were randomly selected) 13% of men and 17% of women over the age of 60 had suffered urinary incontinence.

Urinary incontinence on Hospital wards is also very common affecting up to 50% of patients on geriatric wards and up to 30% on acute NHS wards. Furthermore, it is commonly managed with containment (pads or catheters) without any proper assessment or any attempt at appropriate treatment (see the National Audit of Continence Care in Older People: NACCOP). Urinary incontinence is associated with falls especially at night, pressure ulcers, skin infections, social isolation. It rarely kills people but sufferers feel ashamed and hide the problem. It may come to dominate their lives, such that they become profoundly depressed. It is often the final reason why older people go into long term care. At least 50% of residents in Nursing Homes in the UK suffer with UI. It can also cause conflict between an individual and their carer.

Evidence based strategies for the treatment and management of UI are known and should be used.

This policy has been written as one of the action plans following the latest National Audit of continence care for older people (NACCOP) in December 2010. The Health Community (primary and secondary care) is committed to wherever possible assessing and managing UI appropriately, thereby improving well being and dignity in patients and also potentially reducing costs. The NSF for Older People published in 2001 emphasised the importance of an integrated continence policy and the dignity agenda from 2009 in the British Geriatric Society emphasises the importance of proper continence promotions. We are seeking to maintain dignity in older patients.

NICE published: Urinary incontinence: the management of urinary incontinence in women, in 2006. This document has also been considered here.

The purpose of this policy is to prevent urinary incontinence where possible, to assess patients with urinary incontinence thoroughly and appropriately wherever it occurs, to manage urinary incontinence starting with a conservative approach before moving to more interventional approaches. Containment should always be the last resort. A further purpose of the policy is to promote dignity and to use evidence based care and to audit performance at regular intervals.

2. SCOPE OF DOCUMENT

This clinical policy applies to:

Staff group(s)

- All healthcare professionals and staff in the wider health community of mid-Trent, who are involved in any way with incontinent patients and all people who are at risk of developing incontinence

Clinical area(s)

- All clinical areas treating and caring for adult patients within Sherwood Forest Hospitals NHS Foundation Trust **and** Nottinghamshire Healthcare NHS Foundation Trust
- The heath community: The Health Community is defined as the Sherwood Forest Hospitals NHS Foundation Trust and Primary Care now represented by the Clinical Commissioning Group, the Mental Health Sector and the Independent sector.

Patient group(s)

- incontinent adult patients and all adults who are at risk of developing incontinence

Exclusions

- Paediatrics (0-17 years)
- Pregnant women in labour and immediately after delivery (See - “Guideline for bladder care during Labour & Post-natal period”

Related Trust policies, guidelines or other Trust documents

- Treatment Pathway for Adults following Bowel Continence Assessment (NHC)
- Policy: The prevention of patient falls (SFH)
- Indwelling Urinary Catheter Insertion Policy (SFH)
- Practice Guidance for Male, Female and Suprapubic Catheterisation (NHC)

3. DEFINITIONS AND/OR ABBREVIATIONS

Urinary incontinence is defined as involuntary urinary leakage. It may occur as a result of a functional abnormality of the lower urinary tract or other illness.

Containment is the use of pads, catheters or sheaths (and others) to contain incontinence when other methods of treatment / management have failed. All methods of treatment and containment aim to improve dignity and quality of life.

CCG – Clinical Commissioning Group (Mansfield & Ashfield / Newark & Sherwood)

SCAS- Specialist Continence Advisory Service

CNA – Continence Nurse Advisor

NHC – Nottinghamshire Healthcare NHS Foundation Trust

4. ROLES AND RESPONSIBILITIES

The Health Community/Trust Board will identify a staff member to take responsibility for the promotion of continence and the assessment and management of incontinence across the Health Community in Mid-Trent. The Continence Committee will recommend that Mr Krishnan Anantharamakrishnan should take the lead with Specialist Continence Clinical Services Lead working in close collaboration.

The Continence Committee will meet on a task and finish basis to discuss issues and to develop, implement and review policies and will be made up of: the clinical leads, continence nurse advisors, service directors, heads of nursing, primary health lead, mental health lead and learning disabilities lead. There will also be representatives of geriatric medicine, gynaecological and obstetrics, urology, physiotherapy, link nurses, link nurse representatives, clinical educator, community nurses and the independent sector. Members of the committee will offer advice about promoting continence and treating it, as well as engaging in active audit and help training.

Clinical Lead for Continence will report annually to:

- Chief Executive Officer and Trust Board (SFHFT)
- Clinical Management Team (SFHFT)
- Clinical Commissioning Groups (Mansfield & Ashfield and Newark & Sherwood)
- Independent Sector

Service Directors / Heads of Nursing will be responsible for the policy being followed on wards.

Continence Nurse Advisor(s) will provide advice and support regarding professional issues, promotion, education and training, assessment, treatment and management for individuals presenting with continence problems.

Women's Health Physiotherapist(s) will provide education for and assessment and treatment of individuals presenting with urinary incontinence in both obstetrics and gynaecology and receive referrals from a wide range of sources

Clinical Commissioning Groups will promote awareness of this policy, follow available referral guidance and protocols and work in conjunction with community and secondary care colleagues to ensure active prevention and diagnosis where possible in a primary care setting.

5. NARRATIVE

5.1 Guidance for the Assessment and Management of UI

Guidance for the Assessment, Treatment and Management of Bladder Problems & Urinary Incontinence in Adults

First line treatment for bladder problems and urinary incontinence

Community (NHC):

Patients are offered appointments at Community Nurse Continence Clinics run by a nurse with relevant continence promotion training, the aim of the service is to offer assessment → diagnosis → treatment; following pathways. (See appendix 1, appendix 2a(i) and appendix 2a(ii)).

Hospital (SFHT):

Patients in hospital presenting with a continence problem to be assessed following pathways and assessment to be undertaken as indicated. Patients in hospital may have transient causes of incontinence; these symptoms often resolve when the patient's condition improves. The aim is to offer assessment → diagnosis → treatment. Discharge must not be delayed due to the continence assessment if this is not the primary reason for admission. The assessment information should be forwarded to the Community Nursing team on discharge (see appendix 5).

Second & third line treatment for bladder problems and urinary incontinence

Patients who present with an unclear diagnosis or a diagnosis which indicates a need for referral on must be referred on following pathways for specialist assessment:

- Specialist Continence Services (NHC)
- Women's Health Physiotherapists (SFHT)
- General Practitioners
- Urology Clinic
- Gynaecology Clinic
- Geriatric Clinic

The urinary incontinence pathway (appendix 1), assessment (appendix 2a(i) and appendix 2a(ii)) and reassessment forms (appendix 2b) for adults have been developed to capture and encompass key variables associated with aetiology of UI. (Guidelines for completion of the urinary incontinence assessment form is also available). For community based patients, these assessments should be carried out by Community Nurses trained in the assessment and management of UI. These assessments will also encompass bladder diary and fluid intake chart (appendix 3), a patient information leaflet titled Your Continence Assessment (appendix 4). For care home and intermediate care patients the same documents apply. For patients in hospital, a shortened assessment form is currently being trialled (appendix 5) and will be available for use in due course alongside the other documents and leaflets.

There is also advice for assessors for old age; (appendix 6).

Once the assessment is complete and a diagnosis is made clinically, then management can start and Community Nurses should employ their knowledge and skills to manage; transient courses (mnemonic: DIAPPERS) and established causes; stress incontinence, urge incontinence, overflow incontinence, mixed incontinence and other. The treatment pathway for adults following urinary continence assessment is helpful here (appendix 7).

The plan and management will include some behavioural therapy; overactive bladder may be usefully managed with bladder retraining and there is a bladder re-training chart (appendix 8). Functional incontinence may be best managed using prompted voiding and there is a prompted toileting chart and additional support information (appendix 9a and appendix 9b). Uro-dynamic stress incontinence is usually managed conservatively with pelvic floor exercises (appendix 10). Overflow incontinence is best managed with clean intermittent self-catheterisation (appendix 11a and appendix 11b). Queen square stimulator may have a role in those with a residual of <400ml. If there is no improvement a referral to secondary care may is the next step.

A Referral Guideline – Urinary Incontinence in women has been produced by a multi-disciplinary group in Primary Care designed to help with initial assessment and management, and also to advise re-referral to secondary care (appendix 12a and appendix 12b).

If problems are identified with constipation, bladder retraining or lower urinary tract infections then leaflets are available for patients (appendix 24, appendix 25 and appendix 26). In addition, a leaflet is also available for patients who may be experiencing issues with sex if they have a bowel or bladder issue (appendix 27).

5.2 Local Integrated Care Teams (NHC, Community)

The Community Nursing Teams provide a network of nurse led community based Continence Clinics (home visit for patients who are house bound) as part of their role. The focus of the service is to promote continence within the clinics; the nurse's offer individualised continence assessment, diagnosis and treatment programmes; including pelvic floor exercises, bladder retraining and individualised toileting programmes. Where diagnosis is unclear and the problems complex they refer to SCAS/Primary/Secondary care; following the pathways. The Community Nurses are competent with intermittent, urethral and suprapubic catheterisation management and they have access to training, education and advice from the SCAS.

Containment is only prescribed where treatment options have been unsuccessful; this includes referral to secondary care. Patients who are prescribed continence products are required to have a re-assessment of their needs.

5.3 Specialist Continence Advisory Services (NHC)

The focus of the Specialist Continence Advisory Service (SCAS) is the promotion of continence and treatment of incontinence. The SCAS provides an education & training programme and professional advice to Community Nursing Teams to enable them to undertake 1st line continence assessments and treatments following pathways, referring on as indicated. The SCAS support patients where 1st line has not worked effectively and patients with complex problems who need a specialist assessment. The Continence Nurse Advisors have skills in teaching pelvic floor exercises, bladder retraining regimes,

individualised treatment programmes, functional difficulties, bladder emptying problems, intermittent catheterisation, urethral and suprapubic catheterisation and aids and appliances to manage incontinence. Containment is only prescribed when all treatment options have been unsuccessful – including referral to secondary care. The service works with Primary Care, the Independent Sector, Social Care and Secondary Care.

5.4 Women's Health Physiotherapist

The Women's Health Physiotherapy team provide preventative education to both obstetric and gynaecological inpatients. Additionally, they provide out-patient treatment for obstetric patients who either are already experiencing continence problems or are at risk of doing so (e.g. 3rd and 4th degree tears). This includes assessment of the pelvic floor and treatment to improve function.

For gynaecology out-patients the team receive the majority of their referrals from the Gynaecological Continence Clinic, but also accept referrals direct from GPs or CNAs. They provide a thorough assessment of symptoms, followed by conservative management, for patients with stress, urge or mixed incontinence. Treatment is aimed at improving pelvic floor muscle strength and endurance by use of individualised exercise programmes. It can include initiation of bladder retraining programmes along with fluid/dietary /lifestyle advice. They are able to utilise electrotherapy and/or biofeedback for women who are unable to activate their pelvic floors (or who have a very weak pelvic floor).

5.5 Gynaecological continence clinic

The gynaecological continence clinic – where there is a pelvic mass a marked prolapse or urinary continence within the year following surgery or evidence of a fistula then referral to gynaecology would be appropriate. Also young women where conservative treatment has failed should be referred to the gynaecology continence clinic. They have access to further urodynamics in that clinic and also work closer with the gynaecological physiotherapists. Weight loss is important in females with stress incontinence.

The gynaecology clinic (and also Geriatric and Urology Clinics) are sometimes referred young, nulliparous women with mental health problems. They are often on neuroleptic medications and may drink large quantities of fluid. This group is difficult to treat, but they merit a full assessment and sometimes working with the psychiatrist can be helpful.

Most menopausal women will benefit from application of topical oestrogen unless contraindicated (appendix 13).

5.6 Geriatric Continence Clinic

Geriatric Continence Clinic: with older patients with multiple pathology and polypharmacy; patients with chronic neurological conditions; patients with learning difficulties; patients with mixed urinary and faecal incontinence would be best referred to the geriatric clinic which is supported by the SCAS (This clinic uses an assessment proforma appendix 14).

5.7 Urology Clinic

Urology Clinic: Those patients with haematuria, with a large residual; those with recurrent urinary tract infections and neurological patients with detrusor sphincter dyssynegia are best seen in urology. A further assessment within the Hospital may include uro-dynamics for example the measuring of flow rates and post void residuals, bladder pressures studies, which is filling and voiding cystometry, plus video cystourethrography. There is a patient information leaflet for uro-dynamics (appendix 15). Further treatment may involve the use of pharmacological agents, for example there is an algorithm that applies to overactive bladder which can be helpful (appendix 16) and for some patients the use of intravesical botox may be appropriate (appendix 17). In others sacral nerve stimulation may be useful and in those with uro-dynamic stress incontinence there is drug therapy and possibly surgery. Male patients who have hesitancy, struggling and urgency nocturia, particularly those with significant post void residual may have prostate problems, and they should be referred to the urology clinic. Tertiary referrals (e.g. for sacral nerve stimulation) usually go to Sheffield, where there is a multi-disciplinary meeting once monthly).

Urology Outreach Team comprise of specialist nurses providing care from 9am to 5pm service 5 days a week across the Trust's catchment area. Outreach team was set up to help care for patients in their home environment with the aim of reducing hospital admissions and aiding early discharge. Patients, carers and other professionals can access the service for help and support avoiding unnecessary admissions. The team also provide education and training to primary and secondary care. For post micturition dribble and pelvic floor exercises for men, use appendix 23.

5.8 Containment

Where treatment is not effective or successful containment maybe prescribed.

Nottinghamshire Integrated Continence Formulary – relevant documents which contain information relating to:

- Indwelling catheters suitable for urethral or supra-pubic use
- Intermittent catheters
- Leg bags and 2-litre drainage bags
- Belly Bags
- Drainage bag sleeves
- Catheter fixation straps
- Catheter Valves
- Sheaths
- Male and Female urinals & urine directors

1. Nottinghamshire Continence Appliance Formulary Codes January 2012 – Community Codes

2. Nottinghamshire Continence Appliance Formulary Codes January 2012 – Hospital Codes

3. Nottinghamshire Integrated Continence Formulary Guidance October 2009. This guide includes average prescribing quantities for GPs.

These should be considered as the first line prescription products throughout the county and compliance to the formulary is audited annually.

All products have been chosen to ensure continuity of care from secondary care through to primary care, including care homes. Therefore products are available through NHS Logistics and on prescription.

Continence Products/Pads for containment

1. Continence Product Prescription Guide – Local Integrated Community Teams
    - Continence products are only prescribed following a comprehensive continence assessment where treatment options have been unsuccessful; this includes referral to secondary care
    - Patients will be expected to provide their own products if required during the assessment/treatment process
    - Products are not provided for light incontinence or faecal soiling
    - Products are provided by a Continence Home Delivery Service – 12 weekly cycle
    - Maximum of 4 products per 24 hours for patients, product provision above these levels must be authorised by the Specialist Continence Advisory Service

2. Continence product prescription guide – Hospital Wards

If treatment using simple methods, drugs and surgery is unsuccessful it may be that containment is required and this would be the use of pads and catheters and there are some guidelines to help with the use of these such as continence formula guidelines which looks at the cost of pads and catheters (appendix 18), urethral catheter (appendix 19), what is a catheter valve (appendix 20), suprapubic catheterisation (appendix 21) management of blocked catheter (appendix 22). Blocked suprapubic catheters can be dealt with by the outreach nurses during working hours. Otherwise patients need to go to the Emergency Department.

5.9 Consent/ mental capacity

Prior to assessing, examining, treating or caring for patients with bladder problems and urinary incontinence, ensure the patient's consent has been gained. If a patient appears to lack capacity undertake a two stage test and if required plan care in the patient's best interests. For further information refer to your organisation's "Consent Policy" and "Mental Capacity Act Policy"

5.10 Documentation and record keeping

Ensure documentation and record keeping is undertaken in-line with your organisational/ professional requirements and where necessary use the specific documentation associated to this policy when caring for patients with bladder problems and urinary incontinence.

6. EVIDENCE BASE / REFERENCES

The details on much of the description in this policy came from a number of sources:

- Department of Health (April 2000) *Good Practice In Continence Services*
- National Institute for Health and Care Excellence (last updated Nov 2015) *CG171 - Guidelines for the Management of Continence in Women*
- National Institute for Health and Care & Excellence (June 2007) *CG 49 – Faecal incontinenc: The management of faecal incontinence in adults*
- J Durrant & J Snape (2003) *Urinary Incontinence in Nursing Homes for Older People*. British Geriatrics Society. Age and Ageing 2003 32: 12-18
- A Ali & J Snape (2004) *Nocturia in Older People*. International Journal of Clinical Practice 58, 4: 366-373
- N Weerasuriya, F Saunders & J Snape (2007) *Urinary Catheters Use and Complications*. CME Geriatric Medicine; 9(3): 91-98

7. EDUCATION AND TRAINING

- For SFH staff, there is no specific training for the application of this policy. Staff are advised to contact a senior colleague or the Trust Lead for Continence if they have any queries.

- The clinical lead for continence will raise awareness through doctors meetings and induction programs

- A program of formal and informal training has been set up for multi-disciplinary staff working in primary care.

- There is a monthly education meeting for primary care staff.

8. MONITORING COMPLIANCE

There will be yearly participation in the National Audit of Continence Care In Older People (NACCOP) (RCP London).

9. CONSULTATION

The following formal Trust groups/committees have been consulted in the developmental process for this policy:

Contributors:	**Communication Channel: e.g.** • **Email** • **1:1 meeting/ phone** • **Group/ committee meeting**	**Date:**
Continence Nurse Advisor, Notts Healthcare and other Notts Healthcare staff	Email/ meetings	Sep 2017
Consultant Geriatricians	Email	27-10-2017
Urogynae Representative	Email	27-10-2017
Urology Representative	Email	27-10-2017

10. EQUALITY IMPACT ASSESSMENT (EIA)

The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origins, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status. An EIA of this policy/guideline has been conducted/ initiated by the author using the EIA tool developed by the Diversity and Inclusivity Committee. (See Appendix 28)

11. KEYWORDS

Incontinent, Continent, Continence

12. APPENDICES – as listed in contents table

Appendix 6

Urinary incontinence in old age

Introduction

Urinary incontinence (UI) is defined as the involuntary leakage of urine, enough to cause bother to the individual. It is prevalent: a MORI poll reported in 1993 (4007 community dwelling adults, randomly selected) 13% of men and 17% of women over 60 years had suffered UI. At least 50% of residents in nursing homes in the UK suffer with UI. The prevalence is higher with greater age.

Aetiology

There are changes that occur in the lower urinary tract (LUT) with age. Bladder capacity, ability to postpone voiding, urethral and bladder compliance, maximum urethral closure pressure and urinary flow rate all decrease with age. Post void residual and the prevalence of inhibited detrusor contractions increase with age. These changes in the LUT predispose to UI, but do not precipitate it. Additional pathological, physiological and pharmacological insults underlie its increased incidence. New UI in old age is likely to be related to factors outside the LUT.

The causes of UI in old age are either transient or established. Transient causes may be recalled using the mnemonic D I A P E R S

D Delirium
I Infection: urinary tract infection - UTI (symptomatic only)
A Atrophic urethritis/vaginitis
P Pharmaceuticals/psychological (especially depression)
E Excess urine output e.g. diabetes, CCF
R Restricted mobility
S Stool impaction

UI is transient in up to 30% of community based older people and up to 50% of acutely ill older people in hospital. There may be more than one transient cause and they may occur on a background of a pre-existing established cause. The established causes of UI (causes related to the LUT) are most commonly detrusor over activity (due to CNS pathology such as stroke, Parkinson's disease or MS, or in association with bladder outlet obstruction), then stress incontinence (common in post menopausal and multiparous women), followed by voiding difficulties (overflow UI) – either related to mechanical outflow obstruction (e.g. BPH) or hyporeflexic bladder (e.g. autonomic neuropathy).
Nocturia caused by nocturnal polyuria (passing more than ⅓ urine at night) is common in older people.

Evaluation

Although the bladder is said to be an unreliable witness, careful history and examination (focusing on LUT symptoms and signs) will result in an accurate diagnosis in about 2/3 of patients.

You should ask about frequency of micturition day and night (normally x 7 or less in 24 hours), nocturia (i.e. rising from bed to pass urine, even once is felt to be abnormal) and urge and urge incontinence (strong desire to void + incontinence). Frequency of incontinence is also important, as are factors which worsen symptoms (e.g. cough in the case of SI and putting a key in the door in the case of detrusor over activity) and patients' attitude to symptoms (positive – more likely to succeed with treatment). Pad use should be enumerated.

Previous history should be sought – obstetric, gynaecological and surgical (important in terms of damage to pelvic nerves, causation of SI and degree of complication of the problem). Other history – diabetes, CCF and drug history may also be relevant (see above).

All patients should have bloods sent for blood, glucose, urea and electrolytes and calcium. Urine should be sent for microscopy, culture and sensitivity.

All patients should complete a frequency/volume chart and have their flow rate (in old age acceptable maximum flow rate = 10 mls/sec) and post void residual measured (normally <50 mls). Frequency/volume chart (see attached) is a useful way of obtaining objective information about a patient's symptoms. Most people, with careful instruction and perhaps with a carer's help, are able to complete a chart for 2 – 3 days. The patient passes urine as normal but measures the volume (with a jug provided) on each occasion and writes the volumes down against the time passed. Details of incontinent episodes and fluid intake are also registered. There are certain patterns which are suggestive of certain conditions. For example frequent passage of small volumes day and night is suggestive of over active detrusor, or daytime episodes of incontinence (and no night time symptoms) with a normal frequency and fairly normal bladder capacity (normal capacity = 300 – 400 mls) suggests SI. In some patients further investigations (e.g. filling and voiding cystometry) may be useful. Initial assessment can be performed by a trained nurse.

Management

Transient causes of UI are usually reversible and can be treated simply, e.g. antibiotics for symptomatic UTI, oestrogen for atrophic urethritis, physiotherapy for restricted mobility and laxatives for impaction.

Drugs causing UI include: Alpha blockers causing stress incontinence in women, loop diuretics causing polyuria, frequency and urgency, ACE inhibitors causing cough and hence stress incontinence and anticholinergics causing retention and overflow. Stopping such drugs, or altering doses may be helpful.
For established causes:

Detrusor over-activity should be managed with habit retraining plus/minus anticholinergic drugs (e.g. Oxybutynin or Tolterodine (but short acting Oxybutynin is not recommended in the elderly)). Prompted voiding is useful with demented patients.

Stress incontinence can be managed using pelvic floor exercises and surgery may have a role in some older patients. Duloxetine (serotonin and noradrenaline reuptake inhibitor) has a role in stress incontinence but should be started at a low dose to lessen side effects.

Voiding problems in men may be caused by BPH and if so, some drugs such as alpha blockers or 5 alpha reductase inhibitors may be useful. In others surgery should be considered.

In the case of hyporeflexic bladder, cholinergic drugs are disappointing, but clean intermittent catheterisation is a very effective form of treatment even in old age.

Nocturnal polyuria may be managed with lifestyle changes (e.g. avoiding evening drinks), an afternoon diuretic or Desmopressin (used with caution).

Many older patients have more than one cause for their lower urinary symptoms, each cause should be tackled in turn.

Some older patients with multiple problems struggle with the above approaches to management and regular voiding (depending on observed bladder capacity) with/without containment would be required.

In Mansfield further advice may be obtained from the Continence Nurse Advisor (ext 4785) or, after initial assessment, by referral to the geriatric continence clinic (ext 5100).

References

Durrant Joanna, Snape Jeremy. Urinary incontinence in nursing homes for older people. Age & Ageing 2003; 32:12-18

Ali A, Snape J. Nocturia in older people: A review of causes, consequences, assessment and management. Int J Clin Pract 2004; 58: 366-73.

Weerasuriya N, Saunders F, Snape J. Urinary catheters: Use and complications. CME Geriatric Medicine 2007; 9 (3): 91-98.

Appendix 13

Guide to use of topical Oestrogens

The dramatic reduction in circulating Oestrogens that follows the menopause induces a number of metabolic and trophic changes. Whilst vasomotor symptoms are by in large self-limiting, changes to the uro-genital tract are progressive.

Uro-genital changes include vaginal atrophy (loss of elasticity, reduction of blood supply and thinning of epithelium), rising of vaginal pH to 6-8 (pre-menopausal 3.5-4.5) with subsequent increased risk of coliform colonisation and urinary tract infections. Atrophy also affects the urethra and bladder trigone leading to stress incontinence, urgency and frequency.

All topical Oestrogens readily reverse changes of atrophy, but effects on urological symptoms are less well documented and the best evidence for 25 micrograms 17 beta oestradiol tablets (Vagifem®).

There is anecdotal evidence that topical application of 0.1% Estriol cream (Ovestin®) in the night directly to the urethral orifice improves efficacy.

All topical Oestrogens are readily absorbed through the vaginal mucosa, particularly when atrophic at the beginning of treatment. However serum Oestradiol levels do not exceed postmenopausal range (less than 20pg/ml). Oestriol is a weak Oestrogen that is not converted to Oestradiol or Oestrone. Nevertheless the use in patients with Oestrogen sensitive malignancies (breast, endometrium) is not recommended. Use vaginal moisturiser (Replens®) instead.

There is no evidence that topical oestrogens - avoiding the “first pass effect”- increase the risk of thromboembolic events.

Preparation available in the UK

Creams				
Gynest®	Estriol 0.01%	twice weekly	80g	£ 4.67
Ovestin®	Estriol 0.1%	twice weekly	15g	£4.45
Pessary				
Ortho Gynest®		twice weekly	15 pessaries	£4.73
Vaginal Tablets				
Vagifem®	10 micrograms Estradiol	twice weekly	24 tabs.	£16.72
	25 micrograms Estradiol	twice weekly	15 tabs	£10.56
Vaginal Estradiol releasing ring				
Estring®	7.5 micrograms Estradiol/24hrs	change every 3 months		£31.42

References:
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Archer D. Efficiency and tolerability of local Oestrogen therapy for uro-genital atrophy. *The Journal of the North American Menopause Society* 2010; 17 No1: 194-203
Suckling JA et al. Local Oestrogen for vaginal atrophy in postmenopausal women. *Cochrane Database of Systematic reviews* 2010
Sturdee DW, Panay N. Recommendations for management of postmenopausal vaginal atrophy. *Cimacteric* 2010; 13:509-522

Appendix 28 –

Equality Impact Assessment (EqIA) Form (please complete all sections)

Name of service/policy/procedure being reviewed: Bladder Problems and Urinary Incontinence Policy			
New or existing service/policy/procedure: Existing policy being reviewed/ updated			
Date of Assessment: 17/11/2017			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	None	None
Gender:	None	None	None
Age:	None	None	None
Religion:	None	None	None
Disability:	None	None	None
Sexuality:	None	None	None
Pregnancy and Maternity:	None	None	None
Gender Reassignment:	None	None	None
Marriage and Civil Partnership:	None	None	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	None	None

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • Information from within the policy and supporting documents

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- None known

Level of impact

From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

- Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment: Dr Sarkar Haider, policy author
Signature:
Date: 17/11/2017

Document control/ supporting information for this clinical document			
Title: **Policy: The Assessment, Treatment and Management of BLADDER PROBLEMS and URINARY INCONTINENCE in Adults across all health sectors in Mid-Trent**			
Document category:	Clinical Policies and Guidelines		
Reference:	CPG-TW-BP&UI		
Version number:	2.1		
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Version History and Practice Changes/ Amendments		
Issue Date	**Version**	**Comments**
17-04-2019	V2.1	• Appendices 23-27 added along with reference to them within the narrative
07-12-2017	v2.0	• No practice changes • Organisation names/ logos and job titles updated • References updated • Training and Education section updated
05-11-2013	v1.0	• New policy

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