

Minimum Standards for Continence Care

in the United Kingdom



Report of the Continence Care steering group 2014

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Foreword

Minimum standards for continence care and education builds upon Cost Effective Commissioning for Continence Care (2011) supported by the All Party Parliamentary Group for Continence care, which identified that proactive assessment and treatment is cost effective. This document provides a template for commissioners, service managers and health care professionals, detailing service specification, education and training required to provide quality services.

All staff that come into contact with an adult who has a bladder and or bowel problem should be trained to assess, treat and refer as required. It is essential to reduce the negative impact and improve the quality of life for all those with bladder and bowel care problems. The cost implication of not providing staff that are competent to proactively diagnose and treat bladder and bowels problems is significant.

This guide has been written and supported by a multidisciplinary team from the United Kingdom Continence Society who are passionate about ensuring quality continence care services are available and effectively delivered.

Baroness Sally Greengross OBE

Chair of the All Party Parliamentary Group for Continence Care



Executive Summary

At the request of the membership of the United Kingdom Continence Society a working group was convened to address the issue of poor education and training for all health care professionals caring for patients with continence needs. The following document has been developed to recommend minimum standards of continence care and training for all staff working across primary, secondary and tertiary care.

Each training module is intended to give a simple overview of the curriculum and minimum standards required to perform an appropriate assessment or implement conservative management at that level. Many guidelines for practice focus on the clinical pathways for patients, however, the guiding principle of this document was to focus on the training and education needs of health care professionals (HCP's) in contact with patients with bladder and/or bowel symptoms and to suggest a framework for service provision.

It is hoped that by setting a minimum standard it will reduce the variations in practice, not only ensuring that all patients with continence needs are identified and treated accordingly by an appropriately trained individual but to also ultimately improve outcomes. It is also anticipated that this document could help to encourage service leads and educators to guide and develop accessible and appropriate training materials (eg e-learning packages, study days etc) to improve continence assessment skills for all HCP's. As well as encouraging vocational training courses (eg current nursing training in the UK) to include continence care as a mandatory part of the syllabus.

Aims of document

This document has been developed to encourage improvements in the standard of continence care across the UK through more robust guidelines for training and service configuration.

It aims to provide an overview of the ideal structure of a continence service, not only in relation to staffing and training but also in relation to the settings of services, available resource and minimum workload to maintain expertise in specialist services.

Each clinical module is designed to give a simple overview of the curriculum and minimum standards required to perform an appropriate assessment or implement conservative management for all patients at every care level.

This could be used by service managers to ensure that staff are appropriately trained and competent to practice, by individual health care professionals (HCP's) to provide a framework for competence and training needs, and also by commissioners to guarantee that robust staff training is integrated into services.

Intended readership and who must have the listed skills and competencies

It is recommended that all health care providers working with patients with continence needs should be aware of this document and their individual responsibilities in relation to the skills and competencies required. It is also expected that all service leads and managers should ensure that appropriate training and support is in place for staff to enable them to achieve competence.

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List of Abbreviations

ANTT	Aseptic non-touch technique
APPG	All Party Parliamentary Group
AUA	American Urological Association
AUS	Artificial urinary sphincter
BAUS	British Association of Urological Surgeons
BSUG	British Society of Urogynaecology
BTX	Botulinum toxin A
CSU	Catheter sample of urine
DOH	Department of Health
EAU	European Association of Urology
FI	Faecal incontinence
GCP	Good Continence Practice
GP	General Practitioner
HCP	Health care professional
ICS	International Continence Society
IPSS	International prostate symptom score
ISC	Intermittent self-catheterisation
IUGA	International Urogynaecology Association
JCST	Joint Committee on Surgical Training
LUT	Lower urinary tract
LUTS	Lower urinary tract symptoms
MDT	Multi-disciplinary Team
MSU	Mid-stream Specimen of urine
MUI	Mixed urinary incontinence

NICE	National Institute for Health and Care Excellence
OAB	Overactive bladder
PFMT	Pelvic floor muscle training
PMETB	Post-graduate Medical Education and Training Board
PROMs	Patient reported outcome measures
PSA	Prostate specific antigen
PTNS	Percutaneous tibial nerve stimulation
QOL	Quality of Life
RCOG	Royal College of Obstetricians and Gynaecologists
RCS	Royal College of Surgeons
SFNUU	Section of Female, Neurological & Urodynamic Urology
SIGN	Scottish Intercollegiate Guideline Network
SNS	Sacral nerve stimulation
SPC	Suprapubic catheter
SUI	Stress urinary incontinence
UKCS	United Kingdom Continence Society
UI	Urinary incontinence
UUI	Urgency urinary incontinence

Introduction

In 2010 the National Audit of Continence Care ⁱ reported that the quality of continence care in the UK remains variable and, in some respects, poor. They found that in the acute and primary care setting 20% of continence assessments are being conducted by providers without any basic training in continence and this is even higher in the care home sector. It was also discovered that there is a lack of structured continence training for all health care professionals in hospitals and mental health trusts. These findings do not sit well with the Department of Health (DOH) document Good Practice in continence services ⁱⁱ, Chapter 3, 3.9, which states that all patients presenting with incontinence should be offered an initial assessment by a suitably trained individual, or, with the recommendations set out in the National Service Framework for Older People ⁱⁱⁱ.

In 2009 an All Party Parliamentary Group (APPG) was launched with the aim 'to break the taboo by raising awareness of continence issues for adults and children and to promote cost effective funding for continence services and product provision'. In 2012 with the passage of the Health and Social Care act ^{iv}, there was increased concern regarding a perceived reduction in incontinence services and restructuring that moved trained clinicians into management roles. Also, as many community continence services were being tendered under Any Qualified Provider it was believed that it would increase the risk of fragmented services and training. The APPG undertook a survey of continence care services in England ^v to further assess these concerns and found that the skill mix within teams had changed with a particular reduction in senior posts, education of the workforce in continence care is of low priority with poor attendance at arranged sessions, and that most education for clinicians is accessed via professional associations.

At the Annual General Meeting of the United Kingdom Continence Society (UKCS) in Bradford 2013, concerns surrounding lack of appropriate training for health care professionals providing continence care were raised by members of the society. At this meeting it was decided that similar to previous work by the society on minimum standards for urodynamics practice in the UK ^{vi}, a working party would be convened to develop a minimum standard of continence care.

Process of Project

In order to develop these standards a series of questions was developed, for which structured and systematic literature searches were then performed. No high level evidence was identified in relation to the effectiveness of implementation of service delivery policies.

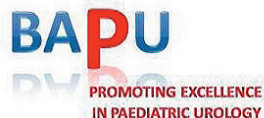
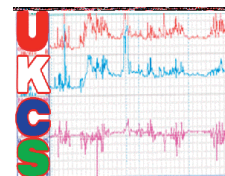
This document has relied on a number of key papers that have described quality standards or guidance for service delivery in the NHS which were used as source material. They are referred to when appropriate in this document.

A meeting of UKCS representatives from specialist nursing, physiotherapy, urogynaecology and urology was convened and met over a period of two days to scope the extent of the proposed document and work collaboratively on initial drafts. An interactive process of editing then followed over a period of 2 months. This was followed by a period of open review on the UKCS website before final publication.

The document has been divided into eight modules which can be utilized as necessary depending on the services offered and the patient groups seen. The modules include:-

1. Structure of Continence services
2. Basic assessment and conservative management of bladder and bowel symptoms
3. Specialist assessment and conservative management of the female lower urinary tract
4. Specialist assessment and conservative management of the male lower urinary tract
5. Specialist assessment and conservative management of patients with a neuropathic bladder
6. Specialist assessment and conservative management of constipation and faecal incontinence
7. Urinary catheterisation
8. Assessment Tools

The document makes no attempt to reproduce existing evidence based clinical guidelines (e.g. NICE^{vii} / EAU^{viii} / SIGN^{viv}) which have been developed through a robust process of evidence evaluation.



References

- i. <http://www.rcplondon.ac.uk/resources/national-audit-continence-care>
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- iv. <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>
- v. www.appgcontinence.org.uk
- vi. http://www.ukcs.uk.net/docs/joint_statement.pdf
- vii. <http://guidance.nice.org.uk/CG171>
- viii. <http://www.uroweb.org/guidelines/>
- viv. <http://www.sign.ac.uk/guidelines/fulltext/88/index.html>

MODULE 1 Structure of Continence Services

Organisational change in the NHS is frequent and recurrent. These standards have therefore been written in a generic way in recognition of the different health service structures across England and the devolved nations. The underlying principles of good practice should apply regardless of the organisational context in which they are delivered.

1. Basic Assessment of Incontinence

Staff

- Healthcare professionals should receive a multi-disciplinary education to promote continence awareness ⁱ.
- Staff undertaking continence assessments must be trained and accredited in basic assessment techniques including identification of red flag symptoms and reasons for early referral to specialist teams (defined below).
- An assessment of continence is undertaken with the goal of making a diagnosis and offering treatment.
- In a minority of cases this goal may be modified to management rather than resolution of symptoms. In these circumstances this change in objective should be actively recorded as this has a significant resource implication that needs to be acknowledged.

Training

- Refer to section of training recommendations.

Setting

- Incontinence is so common that it is logical that initial assessment should occur in the community (including the patient's home) or in acute or long term care settings when patients first present there ⁱⁱ.
- Assessment should also take place in assisted care facilities and take account of specific group needs such as elderly mentally infirm and those with special needs.
- It should not be necessary to refer a patient to a specialist service in order for a basic assessment of continence to take place and therefore most services should have a basic level of continence awareness and training.
- A common assessment process should be feasible irrespective of setting.

Patients

- These include all patients with urinary and/or faecal incontinence, including care and nursing home residents, pregnant women, people with long term mental (including dementia) or physical disabilities, the frail elderly and those where access to healthcare is restricted.
- A continence care plan relevant to both the bladder/bowel symptoms and the underlying condition should be formulated for each individual ⁱⁱⁱ.

Information

- Information about normal and abnormal bladder/bowel function and the basics of self-management should be provided at the initial assessment to both patients and carers.
- A range of information should always be available to health care professionals who are the first point of clinical contact ^{iv, v}.
- A support package for patients and in some cases a key worker should be provided. A defined review date should be included.

Equipment / Facilities

- Simple assessment tools such as bladder and bowel questions, as part of a holistic nursing assessment, screening questionnaires, symptom questionnaires, frequency volume charts or bladder diaries, and should be available for basic assessments. In addition, a HCP with the knowledge of the indications for and the skills to use a bladder scanner for the assessment of post void residual urine, should be part of the continence service.
- Facilities for documentation, record keeping, office space and adequate clinical space to discuss embarrassing issues in private should be available.

Supporting Services

- Knowledge of available specialist teams (defined below) in the locality and a knowledge of referral pathways to those teams is required. Referral to urodynamics studies in secondary care should be readily available.

Workload

- No minimum level of workload is recommended as it is possible for anyone who has initial contact with patients (for instance Health Care Support Workers) to deliver this level of care provided they have appropriate training.

Performance monitoring

- Records should be kept of the number of people who have been assessed and the pathways taken e.g.; simple advice given, containment products, referral to specialist team and alignment with national targets for specific groups.

Audit

- As per local policy or in line with individual HCP's personal development plan (PDP).

2. Specialist Assessment**Staff**

- Staff should work as part of a multidisciplinary team with effective links to care providers within a network such that the patient can access the full range of effective treatment modalities in a seamless manner.
- The team will include a minimum of continence nurses and specialist physiotherapists as well as, urogynaecologists and urologists, colorectal surgeons and gastroenterologists who specialise in functional pelvic conditions.

Training

- Refer to section of training recommendations.

Setting

- Specialist assessment will normally occur within a secondary care setting in a dedicated clinical unit.

Patients

- These will include patients who have failed initial treatment for UI, men with lower urinary tract symptoms (LUTS), UI or FI co-existing with neurological disease, combined UI and FI, women with pelvic organ prolapse and some patients with voiding disorders.

Information

- Written information for sufferers and carers, on a full range of normal bladder/bowel function, abnormal function and treatment options should be readily available.
- Staff should be able to offer appropriate coherent explanation to each patient on their condition and support them in their decisions regarding treatment.

Equipment / Facilities

- The equipment and facilities as described for the basic assessment of incontinence should be available.
- All equipment should be maintained according to manufacturer's standard.
- A clinical facility should have space for undertaking a private consultation and intimate clinical examination. All aspects of care should be provided in a compassionate and empathetic manner to ensure all patient needs are met. Healthcare workers should be available to chaperone patients and assist during embarrassing tests and intimate clinical examination ^{vi}.
- The team must be able to offer advice about containment, products and devices and full storage facilities for these must be available.

Supporting Services

- Radiology services should be readily accessible.
- Specialist teams should streamline patient journey and refer directly into more advanced services eg; Neurourology / Paediatrics / Urogynaecology / Functional Urology and Colorectal clinics.

Workload

- For community continence services the NHS benchmarking audit recommend an average yearly workload of 458 patients per member of full time staff ^{vii}.
- For units where patients have been referred for urodynamics, a unit should maintain a minimum workload as recommended in the UKCS minimum standards for urodynamic practice ^{viii}.

Performance monitoring

- Regular audit of outcomes and assessment of performance should be undertaken.
- Users and stakeholders should be involved in all aspects of planning and delivery of service and in monitoring for purposes of quality assurance.

3. Behavioural and physical therapies

Staff

- Staff should work within a multi-disciplinary team, be appropriately trained, and familiar with relevant evidence based guidance.
- Staff will comprise specialist physiotherapists, continence advisors, other health professionals e.g. district nurses or GPs with an interest in UI.

Training

- Refer to section on training recommendations.

Setting

- Males and females with UI or FI should have access to appropriate physical and behavioural treatments within primary and secondary care. Patients in the community should have direct access to these therapies without the need for referral to secondary care.

Patients

- Includes all patients identified with a bladder or bowel problem who are at the beginning of the care pathway.
- Patients with persistent UI should be referred for further assessment by a gynaecologist or urologist with an interest in continence to consider surgical options as per NICE guidance ⁱ.
- All children should be offered assessment by a Paediatric Continence Advisor ^{ix}.
- Patients with SUI or MUI should be offered instruction in pelvic floor muscle training. For women, it is recommended that the HCP who is the first point of contact should discuss pelvic floor muscle exercises and explain to that patient that a vaginal examination is essential to ensure that they are contracting the correct muscles. If the HCP is not competent in performing a vaginal examination to assess pelvic floor muscle strength and the patient gains no benefit from self-directed exercises, they should be referred to a pelvic floor physiotherapist or suitably trained nurse for a supervised pelvic floor muscle training programme for at least three months.
- Patients with overactive bladder symptoms should be offered bladder training for a minimum of six weeks by an appropriately trained professional.
- Patients with symptomatic pelvic organ prolapse should be offered a specialist gynaecological assessment or review by a women's health physiotherapist.

Information

- Written information on a full range of bladder function, abnormal function and lifestyle modifications should be readily available to patients and carers.
- Staff should be able to provide verbal and written explanation on treatment options such that patients have a realistic expectation on outcomes.

Equipment

- A continence team should have access to dedicated space and equipment similar to that for undertaking a basic continence assessment.
- Additional treatment modalities such as neuromodulation, including biofeedback, and electrical stimulation for male and females with UI should be available.

Workload

- There is no recommended minimum workload. Workload and clinical practice should conform to guidance issued by the relevant Royal College or professional body and be sufficient to maintain as a specialist area of practice.

Monitoring Performance

- Access to physical and behavioural therapies should be monitored through user and stakeholder involvement.
- Outcomes assessment of these therapies should be monitored through PROMs.

Supporting Services

- These services should be provided within a continence network to facilitate communication between primary, secondary and tertiary services and seamless referral between health professionals within the network.

4. Surgical interventions for uncomplicated incontinence

(Includes primary surgery for stress urinary incontinence and overactive bladder refractory to simple conservative therapies and pharmacotherapy).

Staff

- Surgery should be performed by surgeons with specialist training and sufficient workload to maintain expertise.
- Surgeons should work in the context of a multidisciplinary team and clinical network.
- Supporting health professionals including ancillary and nursing staff should be available.

Training

- Surgeons who undertake continence surgery should have undertaken an approved training programme such as RCOG Subspecialty training or advanced training skills module in Urogynaecology, Female Urology or equivalent supervised training ^{x, xi}.
- Surgeons who undertake procedures that are new or undertaken for the first time should adhere to NICE recommendations for clinical governance ⁱ.

Setting

- Secondary care should be able to offer specialist conservative therapies as part of the package of care, some of which may be available in primary care.
- Surgical options should be discussed at an MDT.
- Treatments which are new or have limited evidence on efficacy such as PTNS should only be used after discussion and agreement by the MDT.
- Botulinum toxin injection should only be performed by health care professionals trained in lower urinary tract endoscopy.

Information

- Patients must be provided with information about all treatment options for UUI or SUI or MUI and allowed time to make personal choices.
- All patients should be offered all options and onward referral to another provider should an appropriate treatment not be available locally.

Essential Equipment/Facilities

- Resources to teach patients ISC, monitor residuals and bladder training.
Facility for performing endoscopic interventions of lower urinary tract.
Operating facility with full capacity to perform vaginal and abdominal surgery.
Inpatient beds and post-operative aftercare.

Supporting Services

- Medical physics, laboratory, radiology, pharmacy support for use of botulinum toxin.
- Centres should be able to demonstrate collaboration with other specialists (Urology/urogynaecology/colorectal) or centres with additional services or expertise within an MDT setting.

Workload

- Interventions for uncomplicated incontinence are usually provided in secondary care setting with enough work to maintain expertise: a population of 250,000 is usually deemed sufficient.
- Only surgeons who undertake a sufficient workload should undertake surgery for SUI and OAB. An annual workload of 20 procedures for each primary UI procedure is recommended ⁱ.
- Surgeons with a caseload of fewer than 5 for any procedure should seek approval through clinical governance committee otherwise a referral pathway should be available through the network ⁱ.
- Recurrent continence surgery is described under the Complex commissioning guide (E10) ^x.

Performance monitoring

- Surgeons should undertake comparative audit of outcomes and participate in national audits through national databases such as BSUG and BAUS database ^{i, xi}
- Surgeons should be able to present their own personal data for key clinical outcomes for all procedures ¹ e.g.,
PTNS – treatment efficacy using validated outcomes pre and post treatment,
BTX – UTI and Self Catheterisation rates,
SUI – validated outcomes at 12 months,
Surgeons should adhere to the Principles of Good Medical Practice.

5. Complex Surgical Interventions

- Includes secondary surgery for female SUI, surgery for male incontinence, incontinence surgery in neuropathic patients, sacral nerve stimulation and major reconstructive surgery for intractable incontinence.

Staff

- Should be performed by surgeons with specialist training and sufficient workload to maintain expertise. Surgeons should work in the context of a multidisciplinary team.
- Surgeons will normally be active members of relevant professional groups – eg; BSUG or BAUS SFNU.

Training

- Specified by Subspecialty training documents in Female Urology, Neurourology and Urogynaecology – see JCST / RCOG websites ^{xii, xiii, xiii}.

Setting

- Will usually occur in hospitals serving a large population- probably in excess of 1 million people.

Information

- Patients must be provided with information about all treatment options for their particular condition and allowed time to make personal choices.

Equipment / Facilities

- Ability to teach patients CISC.
- Advanced operating facility used to performing complex vaginal or abdominal surgery.
- Aftercare – patients should be managed peri-operatively on specialised wards that regularly care for patients undergoing complex continence surgery and are able to carry out;
 - Vaginal examinations.
 - IV fluid and electrolyte replacement.
 - Advanced pain control.
 - Regular monitoring of drainage.

Supporting Services

- For BTX – pharmacy support for use of botulinum toxin,
For PTNS,
For major surgery – Intensive therapy, nephrology, general surgery.

Workload

- PTNS and BTX - usually provided in secondary care setting with enough work to maintain expertise – population of 250,000 sufficient.
- Major surgery and SNS require larger populations and more centralised services to support workload.

Performance monitoring

Surgeons should participate in national audits and be able to present key clinical outcomes for all procedures eg;

- PTNS – treatment efficacy using validated outcomes pre and post treatment
BTX – UTI and Self Catheterisation rates
- Services for Faecal incontinence should comply with the standards outlined by the RCS ^{xv}

Recommendations for Service Configuration

- Service delivery should be organized through clinical collaboration and agreed local pathways. There should be Regional Clinical Networks which are able to offer the complete range of incontinence therapies and within which it is easy to cross refer patients within service level agreements. They will be comprised of locally based continence teams as well as regional centres able to provide a wider range of treatment options. These arrangements need to be able to transcend transient organisational structures and should be based on strong clinical collaboration.

Care will be delivered at a number of levels

Level 1 - Community based Staff (including staff working in nursing homes) “Link nurses” (see appendix on basic continence assessment)

- All healthcare professionals should be able to identify sufferers and liaise with providers in their locality.
- Primary care should be the first level of care for those suffering with incontinence ⁱⁱ.
- For community continence services, 1.3 whole time equivalent (WTE) members of clinical staff are recommended per 100,000 population with an additional 0.45 WTE non-clinical staff for the service ^{vii}.
- Good practice should be shared among those undertaking assessments through the development of a wider Continence Specialist team to whom those working, apart from the specialist team will link, and have ready access for advice and support and educational resources.
- Those working in isolated settings away from the specialist team should attend regular updates and clinical meetings where cases may be discussed.
- Patients who fail to respond to treatment should be able to be referred directly from the community based practitioner to the specialist team.
- Local care pathways and common evidence based policies should be available for the management of incontinence in the community.
- Users and carers should be involved in the planning, provision and assessment of services within the community ⁱⁱ.

Level 2 – Specialist Continence teams

- A continence specialist team will normally be located in a secondary care facility and will usually comprise; specialist nurses including paediatric nurse specialists, specialist physiotherapists, urologists and/or gynaecologist with particular interest and training in management of incontinence and pelvic floor disorders.
- These teams would normally be able to offer basic and specialist assessment, advice on containment and appliances, conservative and drug management and primary surgery for uncomplicated urinary incontinence.
- Local continence teams should hold MDT meeting as described in section and undertake regular performance reviews and audit.
- The specialist team will provide support, training and ready access for community based “link nurses” as defined above. Patients should be able to access the specialist team directly from the community based link nurses.
- Such a team will normally support a population of more than 100,000 ^{vi}.
- These teams should work to evidence based policies and guidelines for the management of lower urinary tract symptoms and other pelvic floor disorders.
- These specialist teams should engage with stakeholders and use benchmarking tools to monitor and improve performance ^{x, vi}.
- Continence leads in related specialties such as geriatric medicine, midwifery, paediatrics, surgery, gastroenterology and coloproctology should be identified to raise awareness and promote continence.
- Surgeons would be expected to have an appropriate workload to maintain surgical skills and work within a multidisciplinary team with expertise in pelvic floor dysfunction.
- Surgical teams would be expected to provide evidence of outcomes for their surgical procedures and to provide surgery in line with evidence based practice guidelines (e.g.; NICE, EAU, AUA, ^{i,ii,iii}).

Level 3 – Local Multidisciplinary Teams

- Patients who have failed conservative management for their UI should have their case discussed in an MDT ⁱ.
- The multi-disciplinary team should comprise a range of health care professionals who may have involvement in the patient's treatments and who have sufficient expertise to review all surgical decisions. This would normally include a specialist urologist, urogynaecologist, specialist nurse and physiotherapist and additional input from other specialists such as Care of the Elderly Physicians and colorectal surgeons ⁱ.
- All MDTs should operate as a part of a wider regional clinical network who should collectively be able to offer the full range of clinical interventions ⁱ.
- Patients with complex incontinence problems e.g. failed SUI surgery or failed botox, patients with complex neurological conditions, post-prostatectomy incontinence should routinely be referred to and assessed by a regionally based MDT. Much of this will be under specialist commissioning ^x.
- Records should be kept of MDT recommendations, which in turn should be clearly reported to GPs and made available to patients. There should be formal reporting of serious and adverse events.
- MDTs should be incorporated into job plans of the individual participants and appropriate administrative support provided, to facilitate record keeping and audit.
- The minimum requirement is of 1 clinical session per week dedicated to this specialist work.
- MDTs should be working to evidence based common pathways procedures/ policies and guidelines.
- Practitioners must be able to show evidence of audit and regular CME related to continence.
- Teams should have meetings at least once per month.
- The MDT also has an important role in promoting awareness of incontinence services and the availability of all effective treatments.
- Services should serve populations of approx 250000. A level of one specialist nurse per 100000 population has been recommended by the APPG.

Level 4 - Regional expert Multidisciplinary teams

- Every regional network should include a regional team who can provide a wider range of expertise and therapies.
- They should be able to deal with:
 - Women with failed stress incontinence therapy.
 - Women with failed first line surgery for UUI (including major reconstructive surgery).
 - Patients with complex neuropathy.
 - Men with postprostatectomy UI, or persistent or recurrent UI after male slings and AUSs.
 - Patient with combined urinary and faecal incontinence.
 - Women with prolapse and urinary incontinence.
- There should be access to expertise in anorectal function. This includes the involvement of a colorectal specialist and access to investigations with anorectal physiology, defaecating proctography and endoanal ultrasound. Conservative treatments should include access to biofeedback and rectal irrigation. There should also be the facility and expertise to undertake specialist reconstructive surgery.
- Regional centres will normally be active in clinical or basic science research in the field of incontinence and will provide specialist training for both medical and nursing personnel.
- Regional teams will normally support populations of over 1M people.
- Some services may only be feasible at a supraregional level e.g. vesicovaginal fistula, and sacral nerve stimulation. These teams would normally support populations of several million people i.e., the number of such teams within the UK will be relatively few. These services will be commissioned as specialist services ^x.

Governance Arrangements

- Multi-agency Advisory Groups.
- Sufferers of urinary incontinence are to be found in the whole of the health and social care sector, and services should be organized through collaboration of the multiple agencies involved. At a local and regional level there should be strategic groups with the following representation:
 - primary care
 - specialist continence services
 - acute and mental health care directorates
 - long term care (high prevalence of UI)
 - voluntary sector
 - education sector (because of enuresis. soiling)
 - private care sector (residential homes with high prevalence of UI)
 - social services
 - service users
 - designated leads for relevant specialties.
- These groups must have board level support and will advise on planning and configuration of continence services at a regional or sub-regional level ^{vi}.
- One important role of this group is to advise and set standards for toilet provision and access within care facilities in all sectors.

Further points for Consideration^v

To be able to deliver the service described above and in accordance with the GCP document one may need to consider the following points as additional factors alluded to in the text above, but not expressly expanded on:

- Need for informal network of continence providers –
- Need for networks to embrace those working in isolation.
- People working in isolation must be linked to local or regional support networks.
- Developing a Service lead from within the network, who has responsibility to ensure that services are integrated. This role is probably best served by someone based in the community rather than secondary care.
- Resources for attendance backfill and administrative support, equipment and consumables.

References

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- xii <http://www.jcst.org/>
- xiii <http://www.rcog.org.uk/education-and-exams/postgraduate-training>,
- xiv <http://www.rcseng.ac.uk/surgeons/training/curriculum>
- xv <http://www.rcseng.ac.uk/healthcare-bodies/docs/Commissioning%20guide%20for%20faecal%20incontinence%20-open%20for%20consultation%2013%20May%20-%2010%20June%202013.pdf/view?searchterm=faecal+incontin>
- xvi http://www.healthcareimprovementscotland.org/previous_resources/process_documentation/nhs_qis__nice_advice.aspx

Useful resources

- <http://www.bladderandbowelfoundation.org>
- <http://www.disabledliving.co.uk/PromoCon/About>
- <https://www.gov.uk/government/publications/essence-of-care-2010>
- <http://www.nice.org.uk/usingguidance/commissioningguides/paediatriccontinenceservice/home.jsp>

MODULE 2 Basic assessment & conservative management of bladder and bowel symptoms

The minimum standards required to initiate a basic continence assessment of bladder and bowel symptoms in men and women are outlined below and can be divided into six categories:

1. **Knowledge base**
2. **Assessment of the patient**
3. **Basic investigations**
4. **Initiating treatment**
5. **Reviewing the outcome of treatment**
6. **Supervision and training**

1. Knowledge base

- Learning outcomes:
 - To demonstrate an appropriate knowledge of anatomy and pathophysiology relevant to continence status.
 - To understand the impact of lower urinary tract and bowel symptoms on men and women.
 - To be able to identify “red flag” symptoms and signs and the need for urgent onward referral.
 - To demonstrate an understanding of the conservative management of bladder and bowel symptoms.
 - Be aware of the potential need for onward referral for continence problems.

2. Assessment of the patient

- Learning outcomes:
 - To demonstrate an ability to assess bladder and bowel symptoms.
 - To be aware of suitable onward referral.
 - To be able to perform a basic focussed clinical examination.
 - To be able to identify other factors which can impact on continence status eg mobility, medications.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of types of incontinence, basic anatomy and pathophysiology in relation to continence status.</p> <p>Knowledge of red flag signs and symptoms (NICE Guideline CG171 and CG97).</p> <p>Awareness of the impact of mobility, manual dexterity and the patient's environment on their continence status.</p>	<p>Ability to take a basic history about continence status from the patient and assess symptom bother and desire for treatment.</p> <p>Examination of the perineum to identify excoriation.</p> <p>Ability to undertake a functional assessment of mobility, manual dexterity and environment.</p>	<p>Observation of continence assessment performed by a competent health care professional.</p> <p>Clinical supervision as required.</p>	<p>Direct observation.</p> <p>Competences.</p>	<p>ICS/IUGA</p> <p>CHS168</p> <p>CC01</p> <p>SCDHSC0219</p> <p>NICE CG40</p> <p>NICE CG171</p> <p>NICE CG97</p> <p>QOL SF (ref ICI)</p>

3. Basic investigations

- Learning outcomes:
 - To demonstrate the ability to perform and interpret dipstix analysis of urine.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Understand the implications of urine testing.</p> <p>Knowledge of "red flags".</p>	<p>Be able to perform and interpret dipstix testing of urine and know when to send MSU.</p> <p>Know when to refer into other pathways such as haematuria pathway.</p> <p>Be aware of the value of bladder / bowel diaries.</p>	<p>Supervised learning with appropriately trained health care professional.</p>	<p>Training record.</p> <p>Direct observation.</p>	<p>CC01</p> <p>CC10</p> <p>CG40</p> <p>CG171</p>

4. Initial management

- Learning outcomes

To demonstrate the knowledge skills and attitudes required to undertake initial continence management.

To demonstrate awareness of treatment options available for urinary/faecal incontinence.

To understand the clinical context of treatment options.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Awareness of co-morbidities and their effect on urinary and bowel symptoms.</p> <p>Knowledge of effective lifestyle interventions and appropriate timing of onward referral.</p> <p>Knowledge of available resources for patient.</p>	<p>Development of treatment plan and agree this with the patient based on initial assessment and basic investigations.</p> <p>Demonstrate basic knowledge of continence aids and products and counsel patient about their correct use.</p>	Direct supervision.	Direct observation.	<p>CHS41</p> <p>CC01</p> <p>CC08</p> <p>CC11</p> <p>CC12</p> <p>CG40</p> <p>CG171</p> <p>Bladder & Bowel Foundation Promocon</p>

5. Reviewing the outcome of treatment

- Learning outcomes

To demonstrate the ability to monitor the effect of treatment.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of potential outcomes of treatments for different symptoms.</p>	<p>Assess the response to lifestyle interventions and continence aids, referencing back to objectives agreed at initial assessment.</p> <p>Awareness of own level of responsibility and onward referral when appropriate.</p>	Direct observation, supervision and feedback.	Direct observation by preceptor.	CG171

6. Training and supervision

1. Training must initially be given under the supervision of an identified preceptor.

References

Skills for Health competences are referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
CC01	Assess bladder and bowel dysfunction
CHS168	Obtain a patient/client history
CHS41	Develop and agree treatment plans for individuals
CC10	Assess residual urine by use of pelvic ultrasound
CC11	Implement toileting programmes for individuals
CC12	Enable individuals to undertake pelvic floor muscle exercises
CC08	Care for individuals using containment products

NICE (National Institute for Health and Care Excellence) guidance : www.nice.org.uk

Ref number	Title
CG171 (replaced CG40)	Urinary incontinence in women
CG148	Urinary incontinence in neurological disease
CG49	Faecal incontinence
CG97	Lower urinary tract symptoms in men

MODULE 3 Specialist assessment & conservative management of female lower urinary tract symptoms

The minimum standards required to initiate specialised conservative treatment of female urinary incontinence are outlined below and can be divided into six categories:

1. **Knowledge base**
2. **Assessment of the patient**
3. **Basic investigations**
4. **Initiating treatment**
5. **Reviewing the outcome of treatment**
6. **Supervision and training**

1. Knowledge base

- Learning outcomes:

To demonstrate an appropriate knowledge of the anatomy and pathophysiology of female lower urinary tract in relation to lower urinary tract dysfunction and continence status.

To understand the impact of lower urinary tract symptoms on women.

To be able to identify “red flag” symptoms and be aware of the need for onward referral for these or other conditions.

To demonstrate an understanding of the types of female urinary incontinence.

To demonstrate an understanding of the conservative management of these conditions.

To be able to set relevant goals and expectations of treatment and arrange appropriate review.

To demonstrate knowledge of the role of the multi-disciplinary team.

2. Assessment of the patient

- Learning outcomes:
 - To demonstrate an ability to assess the symptoms of urinary incontinence and their impact on overall QoL.
 - To demonstrate an ability to categorise the type of incontinence.
 - To demonstrate a knowledge of relevant validated symptom and QoL questionnaires.
 - To be able to form a clinical diagnosis.
 - To be able to perform a relevant clinical examination.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of ICS/IUGA definitions of incontinence.</p> <p>Knowledge of female anatomy and pathophysiology in relation to continence status including when the presence of pelvic organ prolapse may affect urinary symptoms.</p> <p>Awareness of the interaction between lower urinary tract symptoms and sexual function.</p> <p>Knowledge of red flag signs and symptoms.</p> <p>Knowledge of bowel symptoms and their potential effect on urinary symptoms.</p> <p>Awareness of co-morbidities and medications that may affect lower urinary tract function.</p> <p>Awareness of the impact of mobility, manual dexterity and the patient's environment on their continence status.</p>	<p>Ability to elicit a focussed history from the patient and link this with knowledge of anatomy and types of incontinence to form a clinical diagnosis including relevant questions regarding bowel and sexual function.</p> <p>Ability to identify red flag symptoms and manage or refer appropriately.</p> <p>Examination of the patient's abdomen for palpable mass or urinary retention.</p> <p>Examination of the perineum to identify prolapse, excoriation and assess pelvic floor contraction.</p> <p>If indicated, rectal examination to exclude faecal impaction.</p> <p>Ability to undertake a functional assessment of mobility, manual dexterity and environment.</p>	<p>Attendance at nurse and doctor led lower urinary tract clinics.</p> <p>Joint visits between learner and competent clinician.</p> <p>Clinical supervision.</p>	<p>Direct observation.</p> <p>Competences.</p>	<p>ICS/IUGA</p> <p>CHS168</p> <p>CC01</p> <p>SCDHSC0219</p> <p>NICE CG40</p> <p>NICE CG171</p> <p>QOL SF (ref ICI)</p>

3. Basic investigations

- Learning outcomes

To demonstrate the ability to perform and interpret dipstix analysis of urine.

To demonstrate the ability to administer, explain and interpret bladder diaries.

To demonstrate the ability to perform a bladder scan to assess post-void residual and act upon the result when necessary.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Understand the implications of urine testing.</p> <p>Knowledge of "red flags".</p> <p>Understand the use and interpretation of bladder diaries.</p> <p>Knowledge of bladder scanners and when to measure post-void residual.</p>	<p>Be able to perform and interpret dipstix testing of urine and know when to send MSU.</p> <p>Know when to refer into other pathways such as haematuria pathway.</p> <p>Be aware of appropriate and inappropriate antibiotic prescribing.</p> <p>Be able to administer, explain and interpret bladder diaries.</p> <p>Competent use of bladder scanner to measure post-void residual and act upon findings including onward referral when appropriate.</p>	<p>Supervised learning with appropriately trained clinician.</p> <p>Training days.</p> <p>Continence module.</p> <p>Clinical Supervision.</p>	<p>Training record.</p> <p>Direct observation.</p>	<p>CC01</p> <p>CC10</p> <p>CG40</p> <p>CG171</p>

4. Initial management

- Learning outcomes

To demonstrate the knowledge, skills and attitudes required to undertake initial management of female urinary incontinence.

To understand the clinical context of treatment options.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of conditions causing LUTS.</p> <p>Knowledge of available treatment options.</p> <p>Awareness of co-morbidities and their effect on urinary symptoms.</p> <p>Knowledge of pharmacotherapy and the effect of drugs on the lower urinary tract.</p> <p>Knowledge of types of urinary incontinence and their appropriate treatments.</p> <p>Knowledge of purpose and interpretation of bladder diaries.</p> <p>Knowledge of lifestyle interventions and appropriate onward referral.</p> <p>Knowledge of bladder training programmes.</p> <p>Knowledge of anatomy of pelvic floor muscles and role of pelvic floor muscles in continence.</p> <p>Knowledge of washable or absorbent products, collecting devices and toileting aids.</p> <p>Knowledge of available resources for patient.</p>	<p>Development of treatment plan and agree this with the patient (and/or carers when appropriate) based on initial assessment and basic investigations including explanation of bladder diary findings to patient and giving advice based on findings.</p> <p>To demonstrate knowledge of impact of lifestyle modifications eg. fluid intake, bowel management, caffeine reduction, weight reduction, smoking cessation.</p> <p>Initiate bladder training and/or pelvic floor muscle training programme and allow 6-12 weeks for optimal treatment. Perform vaginal and rectal examination where appropriate.</p> <p>Understanding of effects of medications on the lower urinary tract.</p> <p>Demonstrate knowledge of available and suitable products and counsel patient about their correct use.</p>	<p>Direct clinical supervision.</p> <p>University based Continence module.</p> <p>Direct observation of colleagues, observation by preceptor.</p>	<p>Direct observation.</p> <p>Case log.</p>	<p>CHS41</p> <p>CC01</p> <p>CC08</p> <p>CC11</p> <p>CC12</p> <p>CG40</p> <p>CG171</p> <p>Bladder & Bowel Foundation</p> <p>Promocon</p>

5. Reviewing the outcome of treatment

- Learning outcomes To demonstrate the ability to monitor the effect of treatment.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
Knowledge of potential outcomes of treatments for different symptoms.	<p>Assess the response to lifestyle interventions, referencing back to objectives agreed at initial assessment.</p> <p>If 6 weeks lifestyle modification and bladder training is ineffective consider moving to the next stage on the treatment algorithm, including explanation of effect and possible side-effects of treatment modalities offered.</p> <p>Monitor effect of PFMT and arrange referral to specialist service if no improvement.</p> <p>Awareness of own level of responsibility and onward referral when appropriate, including when to refer to the MDT.</p>	<p>Direct observation of preceptor.</p> <p>Direct supervision and feedback.</p>	<p>Direct observation by preceptor.</p> <p>Case based discussion.</p>	CG171

6. Training and supervision

1. Training must initially be given under the supervision of an identified preceptor.
2. Access to national training courses and continence modules.
3. Written evidence of observations of clinical practice must be undertaken and completed to satisfaction of preceptor before trainee is deemed competent.
4. Access to an MDT to discuss case management.

References

Skills for Health competences referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
CC01	Assess bladder and bowel dysfunction
CHS168	Obtain a patient/client history
CHS41	Develop and agree treatment plans for individuals
CC10	Assess residual urine by use of pelvic ultrasound
CC11	Implement toileting programmes for individuals
CC12	Enable individuals to undertake pelvic floor muscle exercises
CC08	Care for individuals using containment products

NICE (National Institute for Health and Care Excellence) guidance: www.nice.org.uk

Ref number	Title
CG171 (replaced CG40)	Urinary incontinence in women
CG148	Urinary incontinence in neurological disease
CG49	Faecal incontinence

MODULE 4 Specialist assessment and conservative management of male lower urinary tract symptoms

The minimum standards required to initiate conservative treatment of male lower urinary tract symptoms are outlined below and can be divided into six categories:

1. **Knowledge base**
2. **Assessment of the patient**
3. **Basic investigations**
4. **Initiating treatment**
5. **Reviewing the outcome of treatment**
6. **Supervision and training**

1. Knowledge base

- Learning outcomes

To demonstrate an appropriate knowledge of anatomy and pathophysiology of the male lower urinary tract in relation to lower urinary tract dysfunction and continence status.

To understand the impact of lower urinary tract symptoms on men.

To be able to identify “red flag” symptoms and be aware of the need for onward referral for these conditions.

To demonstrate an understanding of the types of male lower urinary tract dysfunction.

To demonstrate an understanding of the management of these conditions.

To be able to set relevant goals and expectations of treatment and arrange appropriate review.

To demonstrate knowledge of the role of the multi-disciplinary team.

2. Assessment of patient

- Learning outcomes

To demonstrate an ability to assess male lower urinary tract symptoms and form a clinical diagnosis.
To be able to perform relevant clinical examinations.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of ICS definitions of lower urinary tract dysfunction and NICE Guidance on male lower urinary tract symptoms.</p> <p>Knowledge of male anatomy and pathophysiology in relation to lower urinary tract symptoms.</p> <p>Knowledge of bowel symptoms and their potential effect on urinary symptoms.</p> <p>Awareness of co-morbidities and medications that may affect lower urinary tract function.</p> <p>Awareness of the impact of mobility, manual dexterity and the patient's environment on their continence status.</p>	<p>Ability to elicit a focussed history from the patient and link this with knowledge of anatomy and types of LUTs to form a clinical diagnosis including relevant questions regarding bowel and sexual function.</p> <p>Ability to identify red flags symptoms and manage or refer appropriately.</p> <p>Perform examination of the abdomen for palpable mass or bladder retention and if indicated digital rectal examination to exclude faecal impaction.</p> <p>Ability to assess the prostate gland including assessment of prostate size (dependant on local policy and training).</p> <p>Ability to undertake a functional assessment of mobility, manual dexterity and environment.</p>	<p>Attendance at nurse and doctor led lower urinary tract clinics.</p> <p>Joint visits between learner and competent clinician.</p>	<p>Direct observation.</p> <p>Discussion.</p> <p>Competences.</p>	<p>ICS</p> <p>EUSC1</p> <p>NICE - CG97</p> <p>CHS 39</p> <p>CHS40</p> <p>PB1</p>

3. Basic Investigations

- Learning outcomes

To demonstrate the ability to perform and interpret dipstix analysis of urine.

To demonstrate the ability to perform urine flow rate and the ultrasound assessment of post-void residual volume.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Understand the implications of urine testing.</p> <p>Knowledge of “red flag” symptoms.</p> <p>Understand the use and interpretation of bladder diaries.</p> <p>Knowledge of bladder scanners and when to measure post-void residual.</p> <p>Knowledge of the role of IPSS and when it should be applied.</p> <p>Knowledge of the role of further investigations such as PSA and renal function tests.</p> <p>Urine flow testing.</p>	<p>Be able to perform and interpret dipstix testing of urine and know when to send MSU.</p> <p>Know when to refer into other pathways such as haematuria pathway.</p> <p>Be aware of appropriate and inappropriate antibiotic prescribing.</p> <p>Be able to administer, explain and interpret bladder diaries.</p> <p>Competent use of flowmeter and bladder scanner to measure flow rate and post-void residual and act upon findings including onward referral when appropriate.</p>	<p>Supervised learning with appropriately trained clinician.</p> <p>Training days.</p> <p>Continence module.</p> <p>Clinical supervision.</p>	<p>Training record.</p> <p>Direct observation.</p> <p>Discussion.</p>	<p>CC10</p> <p>CHS 76</p> <p>CHS 83</p>

4. Initiating Treatment

- Learning outcomes

To demonstrate the knowledge, skills and attitudes required to undertake first line treatment of male LUTS.
To understand the clinical context of treatment options.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of conditions causing LUTS in men.</p> <p>Knowledge of available treatment options.</p> <p>Awareness of co-morbidities and their effect on LUTS.</p> <p>Knowledge of pharmacotherapy and the effect of drugs on the lower urinary tract.</p> <p>Knowledge of lifestyle interventions.</p> <p>Knowledge of bladder training programmes.</p> <p>Knowledge of when onward referral is appropriate.</p> <p>Knowledge of washable or absorbent products, collecting devices and toileting aids.</p> <p>Knowledge of available resources.</p>	<p>Development of treatment plans and agree this with the patient based on initial assessment and basic investigations including explanation of bladder diary findings to patient and giving advice based on findings.</p> <p>To demonstrate knowledge of impact of lifestyle modifications eg. fluid intake, bowel management, caffeine reduction, weight reduction, smoking cessation.</p> <p>Initiate bladder training programme and/or pelvic floor muscle training and allow 6-12 weeks for optimal treatment.</p> <p>Understanding of effects of medication on the lower urinary tract.</p> <p>Demonstrate knowledge of available and suitable products and counsel patient about their correct use.</p>	<p>Direct supervision.</p> <p>University based Continence module.</p> <p>Direct observation of colleagues, observation by preceptor.</p>	<p>Direct observation.</p> <p>Case log.</p>	<p>CHS 41</p> <p>Bladder & Bowel Foundation Promocon.</p>

5. Reviewing the outcome of treatment

- Learning outcomes To demonstrate the ability to monitor the effect of treatment.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
Knowledge of potential outcomes of treatments for different symptoms.	<p>Assess the response to lifestyle interventions, referencing back to objectives agreed at initial assessment.</p> <p>If 6 weeks of lifestyle modification and bladder training is ineffective consider offering moving on to the next stage of the treatment algorithm, including explanation of effect and possible side effects of treatment modalities offered.</p> <p>Monitor effect of PFMT and arrange referral to specialist service if no improvement.</p> <p>Awareness of own level of responsibility and onward referral when appropriate, including when to refer to the MDT.</p>	<p>Direct observation by preceptor.</p> <p>Direct supervision and feedback.</p>	<p>Direct observation by preceptor.</p> <p>Case based discussion.</p>	PE1

6. Training and supervision

1. Training must initially be given under the supervision of an identified preceptor.
2. Access to national training courses and continence modules.
3. Written evidence of observations of clinical practice must be undertaken and completed to satisfaction of preceptor before trainee is deemed competent.
4. Access to an MDT to discuss case management.

References

Skills for Health competences referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
CC 10	Male lower Urinary tract symptoms
PB1	Male Digital rectal examination
CC12	Pelvic Floor Exercises
PE1	Enable individuals to make informed health choices and decisions
CHS 76	Obtain informed consent for interventions or investigations
EUSC1	Take a presenting history from an individual to inform assessment
CHS 39	Assess an individual with a suspected health condition
CHS40	Determine a diagnosis of an individual's health condition
CHS 83	Interpret and report on the findings of investigations
CHS 41	Develop and agree treatment plans for individuals

NICE (National Institute for Health and Care Excellence) guidance: www.nice.org.uk

Ref number	Title
CG97 Quality Standard	Lower urinary tract symptoms in men

MODULE 5 Specialist assessment & conservative management of patients with a neuropathic bladder

The minimum standards required to assess and manage patients with a neuropathic bladder are outlined below and can be divided into six categories:

1. **Knowledge base**
2. **Assessment of the patient**
3. **Basic investigations**
4. **Initiating treatment**
5. **Reviewing the outcome of treatment**
6. **Training and supervision**

1. Knowledge base

- Learning outcomes

To demonstrate an appropriate knowledge of anatomy and pathophysiology of the urinary tract in relation to lower urinary tract dysfunction and continence status.

To understand the alteration in lower urinary tract function in patients with neurological disorders

To understand the impact of lower urinary tract symptoms in neuropathic patients

To be able to identify “red flag” symptoms and be aware of the need for onward referral for these or other conditions.

To demonstrate an understanding of the management of these conditions.

To be able to set relevant goals and expectations of treatment and arrange appropriate review.

To demonstrate knowledge of the role of the multi-disciplinary team.

2. Assessment of patient

- Learning outcomes

To demonstrate an ability to assess urinary symptoms in patients with neuropathic bladders and form a clinical diagnosis.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of ICS definitions of lower urinary tract dysfunction and NICE guidance on male and female lower urinary tract symptoms.</p> <p>Knowledge of NICE guidance on lower urinary dysfunction in neurological disease.</p> <p>Knowledge of male and female anatomy and pathophysiology in relation to continence status.</p> <p>Knowledge of neurological symptoms that can affect lower urinary tract dysfunction and sexual function.</p> <p>Knowledge of high risk and low risk bladder.</p> <p>Knowledge of bowel symptoms and their potential effect on urinary symptoms.</p> <p>Knowledge of red flag signs and symptoms.</p> <p>Awareness of other co-morbidities and medications that may affect lower urinary tract function.</p> <p>Awareness of the impact of mobility, manual dexterity and the patient's environment on their continence status.</p> <p>Knowledge of autonomic dysreflexia.</p>	<p>Ability to elicit a focussed history from the patient and link this with knowledge of anatomy and types of incontinence in neurological disease to form a clinical diagnosis including relevant questions regarding bowel and sexual function.</p> <p>Ability to identify red flag symptoms and manage or refer appropriately.</p> <p>Examination of the patient as per specialist assessment for men and women.</p> <p>Ability to undertake a functional assessment on mobility, manual dexterity and environment.</p> <p>Ability to identify patients at risk of upper tract dysfunction and refer appropriately.</p> <p>Ability to recognise and manage patients at risk of autonomic dysreflexia.</p> <p>Ability to perform reassessment of bladder symptoms if neurological symptoms deteriorate or disease progresses.</p>	<p>Attendance at a nurse specialist and doctor led clinics for management of patients with neuropathic bladders in primary or secondary care.</p> <p>Continence assessment module.</p> <p>Attendance at a basic study day / workshop on neuropathic bladder dysfunction.</p>	<p>Direct observation or discussion.</p>	<p>EUSC 1</p> <p>CHS 39</p> <p>CHS40</p> <p>CHS 168</p> <p>CC01</p>

3. Basic Investigations

- Learning outcomes

To demonstrate the ability to perform and interpret dipstix analysis of urine.

To demonstrate the ability to perform a bladder scan to assess post-void residual and act upon the result when necessary.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Understand the implications of urine testing.</p> <p>Knowledge of “red flag” symptoms.</p> <p>Understand the use and interpretation of bladder diaries.</p> <p>Knowledge of bladder scanners and when to measure post-void residual.</p> <p>Knowledge of the role of a neurological examination.</p>	<p>Be able to perform and interpret dipstix testing of urine and know when to send MSU.</p> <p>Know when to refer into other pathways such as haematuria pathway.</p> <p>Be aware of appropriate and inappropriate antibiotic prescribing.</p> <p>Be able to administer, explain and interpret bladder diaries.</p> <p>Competent use of bladder scanner to measure post-void residual and act upon findings including onward referral when appropriate.</p> <p>Be able to evaluate need for renal function tests and referral for urinary tract ultrasound.</p>	<p>Attendance at national or local education events.</p> <p>Supervised learning with appropriately trained clinician.</p> <p>Training days.</p> <p>Continence module.</p> <p>Clinical supervision.</p>	<p>Training record.</p> <p>Direct observation.</p>	<p>CC10</p> <p>PB1</p> <p>CHS 76</p> <p>CHS 83</p>

4. Initiating Treatment

- Learning outcomes

To demonstrate the knowledge, skills and attitudes required to undertake first line treatment of neuropathic LUTS.

To understand the clinical context of treatment options.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of conditions causing LUTS in neuropathic patients.</p> <p>Awareness of co-morbidities and their effect on urinary symptoms.</p> <p>Knowledge of pharmacotherapy and the effect of drugs on the lower urinary tract.</p> <p>Knowledge of types of urinary incontinence and their appropriate treatments.</p> <p>Knowledge of purpose and interpretation of bladder diaries.</p> <p>Knowledge of lifestyle interventions and appropriate onward referral.</p> <p>Knowledge of bladder training programmes.</p> <p>Knowledge of anatomy of pelvic floor muscles and role of pelvic floor muscles in continence.</p> <p>Knowledge of washable or absorbent products, collecting devices and toileting aids and available resources.</p> <p>Knowledge of when long-term indwelling catheterisation (urethral or supra-pubic) or intermittent (self) catheterisation should be considered.</p>	<p>Development of treatment plan and agree this with the patient based on initial assessment and basic investigations including explanation of bladder diary findings to the patient and giving advice based on findings.</p> <p>To demonstrate knowledge of impact of lifestyle modifications eg. toileting regimens, fluid intake, bowel management, caffeine reduction, weight reduction, smoking cessation.</p> <p>Initiate bladder training and/or pelvic floor muscle training programme and allow 6-12 weeks for optimal treatment.</p> <p>Perform vaginal/rectal examination where appropriate.</p> <p>Understanding of effects of medications on the lower urinary tract and neurological symptoms.</p> <p>Demonstrate knowledge of indications and management of long term urethral and suprapubic catheters and ISC.</p> <p>Demonstrate knowledge of available and suitable products and counsel patients about their correct use.</p>	<p>Direct clinical supervision.</p> <p>Direct observation of colleagues, observation by preceptor.</p> <p>University based continence module.</p>	<p>Direct observation.</p> <p>Case log.</p>	<p>CHS 41</p> <p>CC02</p> <p>CC04</p> <p>CC06</p> <p>CC 11</p> <p>SCDH</p> <p>SC0219</p>

5. Reviewing the outcome of treatment

- Learning outcomes To demonstrate the ability to monitor the effects of treatment.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of long term chronic neurological conditions.</p> <p>Knowledge of potential outcomes of treatments for different symptoms.</p>	<p>Assess the response to lifestyle interventions, referencing back to objectives agreed at initial assessment.</p> <p>If 6 weeks lifestyle modification and bladder retraining is ineffective consider moving to the next stage on the treatment algorithm, including explanation of effect and possible side effects of treatment modalities offered.</p> <p>Monitor the effect of PFMT and arrange referral to specialist serviced if no improvement.</p> <p>Awareness of own level of responsibility and onward referral when appropriate, including when to refer to the MDT.</p>	<p>Direct observation by preceptor.</p> <p>Direct supervision and feedback.</p>	<p>Direct observation by preceptor.</p> <p>Case based discussion.</p>	PE1

6. Training and supervision

1. Training must initially be given under the supervision of an identified competent preceptor.
2. Within the first 12 months of practical training the trainee should attend a relevant theoretical course.
3. Written evidence of observations of clinical practice and formal testing of a minimum of 10 cases must be undertaken and completed to satisfaction of preceptor before trainee is deemed competent to practice unsupervised.
4. Attendance at a regular MDT to discuss interesting or challenging management of cases seen.

References

Skills for Health competences referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
CC 10	Male lower Urinary tract symptoms
CC12	Pelvic Floor Exercises
PE1	Enable individuals to make informed health choices and decisions
CHS 76	Obtain informed consent for interventions or investigations
EUSC1	Take a presenting history from an individual to inform assessment
CHS 39	Assess an individual with a suspected health condition
CHS40	Determine a diagnosis of an individual's health condition
CHS 83	Interpret and report on the findings of investigations
CHS 41	Develop and agree treatment plans for individuals

NICE (National Institute for Health and Care Excellence) guidance: www.nice.org.uk

Ref number	Title
CG171 (replaced CG40)	Urinary incontinence in women
CG97	Lower urinary tract symptoms in men
CG148	Urinary incontinence in neurological disease

MODULE 6 Specialist assessment & conservative management of constipation and faecal incontinence

The minimum standards required to initiate specialised conservative treatment of constipation and faecal incontinence are outlined below and can be divided into six categories:

1. **Knowledge base**
2. **Assessment of the patient**
3. **Basic investigations**
4. **Initiating treatment**
5. **Reviewing the outcome of treatment**
6. **Training and supervision**

1. Knowledge base

- Learning outcomes

To demonstrate an appropriate knowledge of anatomy and pathophysiology of the gastro intestinal tract in relation to faecal incontinence and constipation.

To be able to identify “red flag” symptoms and be aware of the need for onward referral for these or other conditions.

To demonstrate an understanding of the types of constipation and faecal incontinence.

To demonstrate an understanding of the conservative management of these conditions.

To be able to set relevant goals and expectations of treatment, initiate long term management and arrange appropriate review.

To demonstrate knowledge of the multi-disciplinary team.

2. Assessment of the patient

- Learning outcomes To demonstrate an ability to assess the symptoms of constipation and faecal incontinence and categorise the type of incontinence.
To be able to form a clinical diagnosis.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of definitions of constipation and faecal incontinence.</p> <p>Knowledge of anatomy and pathophysiology of the gastro intestinal tract in relation to constipation and faecal continence status.</p> <p>Knowledge of red flag, signs and symptoms, two week cancer wait target, clostridium difficile, autonomic dysreflexia.</p> <p>Knowledge of urinary symptoms and pelvic organ prolapse and their potential effect on bowel symptoms.</p> <p>Knowledge of co-morbidities that may affect faecal incontinence and constipation.</p> <p>Knowledge of medications that may affect faecal incontinence and constipation.</p> <p>Awareness of the impact of mobility, manual dexterity and the patient's environment on their continence status.</p>	<p>Ability to elicit a clear history from the patient and link this with knowledge of anatomy and types of dysfunction to form a clinical diagnosis.</p> <p>Ability to identify red flag symptoms and manage or refer appropriately.</p> <p>Examination of the patient's abdomen and rectum for palpable faecal impaction and anal sphincter tone.</p> <p>Vaginal examination to assess for the presence of pelvic organ prolapse and awareness of the impact that this may have on symptoms.</p> <p>Able to identify medications that may cause faecal incontinence or constipation.</p> <p>Ability to undertake a functional assessment of mobility, manual dexterity and environment.</p>	<p>Local education events on constipation and faecal incontinence, anatomy and type of incontinence.</p> <p>Joint visits between learner and competent clinician.</p> <p>Bowel management module.</p>	<p>Direct observation.</p>	<p>Drossman 2006 Emmanuel 2004 Emmanuel 2013 MASCIP 2009 NICE 2007 RCN 2012 CC01 CHS4 CHS6 CHS38 CHS39 CHS46 CHS76 CHS167 CHS168 IPIC1 IPIC2 EUSC1 EUSC07 www.nice.org.uk/cgo27 PHARM04</p>

3. Basic investigations

- Learning outcomes

To demonstrate the ability to use food, drink and bowel diaries and act upon the results.

To demonstrate the ability to perform a digital rectal examination and interpret results.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of the application and interpretation of bowel diaries.</p> <p>Knowledge of tissue viability and risk assessment for patients with faecal incontinence.</p> <p>Knowledge of "red flags".</p> <p>Recognise when chronic constipation can cause urinary symptoms and increase risk of urinary tract infection.</p>	<p>Be able to administer, explain and interpret bowel diaries-including consistency, frequency of stool, form (Bristol stool chart) and amount.</p> <p>Ability to collect a stool specimen and act on results.</p> <p>Know when to refer into other pathways such as 2 week wait pathway or for more complex investigations.</p> <p>Able to complete a skin care assessment for patients at risk from faecal incontinence. Give advice regarding skin cleansing and protection.</p>	<p>Attendance at nurse/physio specialist clinics.</p> <p>Mandatory training (infection control, manual handling).</p> <p>Tissue viability training observation.</p> <p>Supervised learning with appropriately trained clinician.</p>	<p>Training record.</p> <p>Direct observation.</p>	<p>Heaton et al 1992</p> <p>CC02</p> <p>CHS54</p> <p>CHS83</p> <p>NICE 2007</p> <p>IPC1</p> <p>IPC2</p> <p>NICE 2012</p> <p>CHS54</p>

4. Initial treatment

- Learning outcomes

To demonstrate the knowledge, skills and attitudes required to undertake initial and long term management of constipation / faecal incontinence.

To understand the clinical context of treatment options.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of anatomy of anal sphincters and pelvic floor muscles and their role in maintaining continence.</p> <p>Knowledge of conditions causing faecal incontinence and constipation and their treatments.</p> <p>Knowledge of lifestyle interventions and appropriate onward referral.</p> <p>Knowledge of available treatment options and skills of occupational therapist, dietician, pharmacist, specialist colorectal nurse, colorectal surgeon and gastroenterologist.</p> <p>Knowledge of autonomic dysreflexia.</p> <p>Knowledge of bowel management training.</p> <p>Knowledge of oral and rectal laxatives.</p> <p>Knowledge of digital anal stimulation.</p> <p>Knowledge of digital rectal evacuation of stool.</p> <p>Knowledge of trans anal irrigation.</p> <p>Knowledge of disposable incontinence products, anal plugs.</p> <p>Knowledge of available information resources for patient.</p>	<p>Development of treatment plan and agree this with the patient / carer based on initial assessment and basic investigations including explanation of bowel diaries and giving advice based on findings.</p> <p>To demonstrate knowledge of impact of lifestyle modifications eg regular eating and improved diet and fluids.</p> <p>Initiate bowel management training and or pelvic floor exercises. Perform vaginal and rectal examination where appropriate.</p> <p>Understanding of the effects of medication on the gastro intestinal tract including the use of oral and rectal medications to treat symptoms.</p> <p>Ability to initiate, perform and teach digital rectal evacuation ,rectal stimulation and rectal irrigation.</p> <p>Demonstrate knowledge of available and suitable products and counsel patients about their correct use.</p> <p>Ability to initiate and teach transanal irrigation to evacuate stool.</p> <p>Explanation of different products available to manage incontinence.</p> <p>Demonstrate knowledge of the voluntary /charity organisations and help provided.</p>	<p>Direct clinical supervision.</p> <p>University based continence module.</p> <p>Direct observation of colleagues, observation by preceptor.</p> <p>Clinical supervision.</p>	<p>Direct observation.</p> <p>Case log.</p>	<p>CC01</p> <p>CC08</p> <p>CC09</p> <p>CC11</p> <p>CC12</p> <p>CHS40</p> <p>CHS41</p> <p>CHS46</p> <p>CHS47</p> <p>CHS52</p> <p>CHS53</p> <p>CHS93</p> <p>PE4</p> <p>GEN14</p> <p>GEN 40</p> <p>GEN 44</p> <p>GEN 47</p> <p>MASCIP2012</p> <p>NPSA 2004</p> <p>Norton 2011</p> <p>CHS210</p> <p>CO09</p>

5. Reviewing the outcome of treatment

- Learning outcomes To demonstrate the ability to monitor the effect of treatment and adapt long term management.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
Knowledge of potential outcomes of treatments for different symptoms.	<p>Assess the response to lifestyle interventions referencing back to objectives agreed at assessment.</p> <p>If lifestyle modification and bowel management training is ineffective then consider moving to the next stage on the treatment algorithm, including explanation of effect and possible side effects of treatment modalities offered.</p> <p>Knowledge of when to refer on to other members of MDT/Tertiary centre.</p>	<p>Direct observation by preceptor.</p> <p>Direct supervision and feedback.</p>	<p>Direct observation by preceptor.</p> <p>Case based discussion.</p>	<p>GEN14</p> <p>CHS47</p> <p>CHS53</p> <p>GEN44</p> <p>GEN47</p> <p>PE1</p> <p>PE2</p> <p>PE4</p> <p>EUSCO7</p> <p>ACA 2011</p>

6. Training and supervision

1. Training must initially be given under the supervision of an identified competent preceptor.
2. Within the first 12 months of practical training the trainee should attend a relevant theoretical course.
3. Written evidence of observations of clinical practice and formal testing of a minimum of 10 cases must be undertaken and completed to satisfaction of preceptor before trainee is deemed competent to practice unsupervised.
4. Attendance at a regular MDT to discuss interesting or challenging management of cases seen.

References

Skills for Health competences referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
CC 01	Assess bladder and bowel dysfunction
CC 08	Care for individuals using containment products
CC 09	Enable an individual to affectively evacuate their bowels
CC 11	Implement toileting programmes for individuals
CC 12	Enable individuals to undertake pelvic floor muscle exercises
EUSC 1	Take a presenting history from an individual to inform assessment
EUSC 07	Prioritise individuals for further assessment treatment
CHS 3	Administer medication to individual
CHS 4	undertake tissue viability risk assessment for individual
CHS 6	Move and position individuals
CHS 39	Assess an individual with a suspected health condition
CHS 40	Determine a diagnosis of an individual's health condition
CHS 41	Determine a treatment plans for individuals
CHS 46	Assess risks associated with health conditions
CHS 47	Monitor and assess individuals following treatment
CHS 52	Plan interdisciplinary assessment of the health and wellbeing of individuals
CHS 53	Evaluate the delivery of care plans to meet the needs of individuals

Ref number	Title
CHS 76	Obtain informed consent for interventions or investigations
CHS 83	Interpret and report on the findings of investigations
CHS 93	Agree a dietary plan for an individual with a specified condition
CHS 167	Obtain valid consent and authorisation
CHS 168	Obtain a patient/client history
CHS 210	Maintain health care equipment medical devices and associated systems
GEN 6	Take a presenting history from an individual to inform assessment
GEN 14	Provide advice and information to individuals on how to manage their own condition
GEN 40	Prepare environments and resources for use during clinical therapeutic activities
GEN 44	Liaise between primary secondary and community teams
GEN 47	Contribute to the development of the multidisciplinary team and its members
IPC 1	Minimise the risks of spreading infection by cleansing and maintaining environments in health and social settings
IPC 2	Perform hand hygiene to prevent the spread of infection
PE 1	Enable individuals to make informed health choices and decisions
PE 2	Manage information and materials for access by patients and carers
PE 4	Agree and plan to enable individuals to manage their health condition
PHARM O4	Provide advice on symptoms and the actions and use of medicines

References

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- Department of Health (2010) Essence of care: benchmarks for respect and dignity, London: DH
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- National Institute of Clinical Excellence (2005) Referral guideline for suspected cancer. Clinical Guideline 27 www.nice.org.uk/cgo27
- National Institute of Clinical Excellence (2012) Infection: control and prevention of health care associated infections in primary and community care: Clinical Guideline CG 139 London NICE
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- National Patient Safety Agency (2004) Improving the safety of patients with established spinal injuries in Hospital, London: NPSA
- Norton C 2011 Guidelines for the use of rectal irrigation(Healthcare professionals) St MARKS Hospital Northwick Park Hospital www.coloplast.uk
- Nursing and Midwifery Council (2008) The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives. London: NM www.nmc-uk.org/code
- Royal College of Nursing (2012) Management of lower bowel Dysfunction including DRE and DRF; a Guidance for Nurses. London www.rcn.org

Other resources

Association of continence advice www.aca.uk.com.uk

Bladder and Bowel Foundation www.bladderaandbowelfoundation.org

Multiple Sclerosis Society www.mssociety.org-uk

National Association for Colitis and Crohns Disease www.nacc.org.uk

Promocon www.promocon.co.uk

RADAR The disability network www.radar.org.uk

Spinal Injuries Association (SIA) www.spinal.co.uk

MODULE 7 Indwelling & intermittent urinary catheterisation (short & long-term)

The minimum standards required for indwelling urinary catheterisation (both short and long-term and urethral and suprapubic) are outlined below:

1. **Knowledge base**
2. **Risk assessment**
3. **Catheter care**
4. **Infection control**
5. **Intermittent self-catheterisation**
6. **Education**
7. **Training and supervision**
8. **References**

1. Knowledge base

- Learning outcomes
 - To demonstrate an appropriate knowledge of anatomy and pathophysiology of the lower urinary tract.
 - To understand indications for catheterisation, including regular review.
 - To consider changes to management including route of catheterisation and whether catheterisation is still necessary.
 - To be able to reduce catheter associated risk including urinary tract infection.
 - To be able to educate patients to manage their products.
 - To be able to identify catheter related complications and manage appropriately.
 - To understand the impact of indwelling urinary catheterisation.
 - To understand the special requirements associated with intermittent self-catheterisation.

2. Assessment of the patient and catheter associated risks

- Learning outcomes To demonstrate an ability to assess the risks associated with insertion of indwelling urinary catheters.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of ICS definitions of lower urinary tract dysfunction.</p> <p>Knowledge of male and female anatomy and pathophysiology in relation to indwelling urethral catheterisation, supra-pubic catheterisation (SPC) and intermittent self-catheterisation (ISC).</p> <p>Knowledge of morbidity and mortality associated with catheterisation.</p> <p>Knowledge of national and local legislation, protocols and guidelines.</p>	<p>Ability to elicit a focussed history from the patient and link this with knowledge of anatomy and type of lower urinary tract dysfunction.</p> <p>Recognition of risk and ability to apply the correct measures to control and manage those risks.</p> <p>Work within own scope of competence and to seek advice if situation beyond this scope.</p> <p>Adherence to legislation, protocols and guidelines relevant to the clinical role and field of practice.</p>	<p>Joint visits between learner and competent clinician.</p> <p>Local education sessions.</p> <p>e-learning modules.</p>	<p>Direct observation or discussion.</p>	<p>PE1</p> <p>CHS76</p> <p>EUSC1</p> <p>CHS39</p> <p>CHS40</p> <p>CHS83</p> <p>CHS41</p> <p>NPSA 2009</p> <p>ICI 2013</p>

3. Catheter care

- Learning outcomes To demonstrate the ability to care for indwelling short and long-term catheters.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
Knowledge of catheter care procedures.	<p>In all care settings clinicians will have the necessary knowledge and skill to care for a patient with an indwelling urethral catheter or SPC as follows:</p> <p>Assessing individual patients to ensure catheterisation is required and regularly re-evaluated.</p> <p>Obtaining a catheter specimen of urine (CSU).</p> <p>Changing urinary drainage bags and valves, ensuring appropriate positioning and support.</p> <p>Emptying a urine bag or catheter valve.</p> <p>Meatal cleansing both prior to catheterization and as part of daily care.</p> <p>Catheter insertion both urethral and supra-pubic (NB initial supra-pubic catheter insertion should be performed in secondary or tertiary care but subsequent changes can be undertaken in the community).</p> <p>Catheter removal, both urethral and supra-pubic.</p> <p>Trial without catheter.</p> <p>Management of catheter associated complications eg blockages / encrustation.</p>	Attendance at national or local catheterisation education events.	Professional portfolio. Direct observation.	GEN6 CC02 RCN 2012 EPIC 2013

4. Infection control

- Learning outcomes

To understand the difference between asymptomatic bacteriuria and urinary tract infection.

To demonstrate knowledge of catheter associated urinary tract infections.

To understand the causes of bacterial colonisation of the urinary tract.

To demonstrate ability to minimise breaches in infection control.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of the potential sources of infection.</p> <p>Knowledge of infection control policies.</p> <p>Knowledge of urinary tract infection definition and when treatment is needed.</p>	<p>Ability and confidence to challenge the need for catheterisation and catheter usage.</p> <p>All staff involved in catheter care must have evidence of training.</p> <p>Ability to perform a risk assessment prior to catheterisation in all care settings.</p> <p>Aseptic non-touch technique (ANTT).</p> <p>Hand washing technique.</p> <p>Adherence to local infection control policies.</p>	<p>Direct observation of ANTT and hand washing.</p> <p>e-learning.</p>	<p>Direct observation.</p>	<p>IPC2</p> <p>IPC7</p> <p>IPC1</p> <p>NICE 2012</p> <p>NICE 2008</p> <p>DoH 2006</p>

5. Intermittent Self Catheterisation (ISC)

- Learning outcomes
 - To demonstrate knowledge of intermittent self-catheterisation.
 - To understand the barriers to teaching patients to perform this.
 - To demonstrate ability to teach patients the correct technique.
 - To demonstrate an awareness of the complications of ISC.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
<p>Knowledge of indications for ISC and alternative management options.</p> <p>Knowledge of different types of products available to patients.</p> <p>Knowledge of the potential sources of infection.</p> <p>Knowledge of and adherence to local infection control policies.</p> <p>Knowledge of available resources for patients.</p>	<p>Ability to teach patients / carers basic anatomy and catheterization using a clean technique.</p> <p>Assess frequency of ISC and develop appropriate regimens for patients.</p> <p>Recognise complications associated with ISC and manage appropriately.</p> <p>Hand washing technique.</p> <p>Ability to educate patients in line with their education and social / religious / psychological needs.</p> <p>Ability to adjust treatment regimen in line with assessments.</p>	<p>Direct observation.</p> <p>Education events on ISC.</p>	<p>Direct observation.</p>	<p>RCN 2012</p>

6. Education

- Learning outcomes To demonstrate ability to educate people using urinary catheters.

Knowledge criteria	Clinical competence and professional skills	Training support	Assessment	References
Knowledge of lifestyle advice, maintaining catheter function, reducing infection and problem solving.	Ability to educate and consult with patient and/or carer/family.	Direct observation Direct supervision and feedback.	Case based discussion.	PE1

7. Training and supervision

1. Training must initially be given under the supervision of an identified preceptor.
2. Within the first 12 months of practical training the trainee should attend a relevant theoretical course.
3. Written evidence of observations of clinical practice and formal testing of a minimum of 3 cases must be undertaken and completed to satisfaction of preceptor before trainee is deemed competent to practice unsupervised.
4. Attendance at a regular MDT to discuss interesting or challenging management of cases seen.

8. References

Skills for Health competences referenced in this document: www.skillsforhealth.org.uk

Ref number	Title
IPC 2	Perform hand hygiene to prevent the spread of infection
GEN 6	Prepare environments and resources for use during clinical/therapeutic activities
GEN 77	Perform first line calibration on clinical equipment to ensure it is fit for use (DRAFT)
IPC 7	Safely dispose of healthcare waste, including sharps, to prevent the spread of infection
CHS 6	Move and position individuals
CC 02	Insert and secure urethral catheters
IPC 1	Minimise the risks of spreading infection by cleaning and maintaining environments in health and social care settings
PE1	Enable individuals to make informed health choices and decisions
CHS 76	Obtain informed consent for interventions or investigations
EUSC1	Take a presenting history from an individual to inform assessment
CHS 39	Assess an individual with a suspected health condition
CHS40	Determine a diagnosis of an individual's health condition
CHS 83	Interpret and report on the findings of investigations
CHS 41	Develop and agree treatment plans for individuals

Further information for indwelling urinary catheterisation

- Access to e-learning modules 'Preventing Healthcare-Associated Infections Associated with Long-term Urinary Catheters' & 'Preventing Healthcare-Associated Infections Associated with Short-term Urinary Catheters' <http://www.nsahealth.org.uk/>
- All medical devices and medicinal products containing chlorhexidine have been identified as being a risk for anaphylactic reaction. <http://www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts>
- Abrams P, Cardozo L, Khoury S & Wein A (2013) (Editors) Incontinence: 5th International Consultation on Incontinence; 5th Edition
- Department of Health (2006) Essential Steps to safe, clean care: urinary catheter care Department of Health, London
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- Loveday H P, Wilson J A, Pratt R J, Golsorkhi M, Tingle A, Bak A, Browne J, Prieto J, Wilcox M (2013) epic3 National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England Richard Wells Research Centre, University of West London (London)
- NICE (2012) Infection Control: Prevention of healthcare-associated infection in primary and community care; Clinical Guideline 139; National Institute for Clinical Excellence
- NICE (2008) Prophylaxis against infective endocarditis: Antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures; Clinical Guideline 64; March; National Institute for Clinical Excellence
- NPSA (2009) Female urinary catheters causing trauma to adult males Rapid Response Report (NPSA/2009/RRR02) National Patient Safety Agency
- RCN (2012) Catheter Care: RCN guidance for nurses Royal College of Nursing http://www.rcn.org.uk/__data/assets/pdf_file/0010/78598/002224.pdf
- Department of Health (2000) Good Practice in Continence Services. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005851
- http://www.healthcareimprovementscotland.org/previous_resources/process_documentation/nhs_qis__nice_advice.aspx
- <http://www.bladderandbowelfoundation.org>
- <http://www.disabledliving.co.uk/PromoCon/About>
- <https://www.gov.uk/government/publications/essence-of-care-2010>
- http://www.ukcs.uk.net/docs/joint_statement.pdf

MODULE 8 Assessment Tools

Types of Assessment tool	Skills to use	Knowledge base	Citation	Ref/access
Bladder diary	<p>Assess voided volumes and interpret fluid intake</p> <p>Interpret symptoms in the context of the bladder diary</p> <p>Initiate first line treatment based on assessment and diary</p>	<p>Physiology of urinary tract (1, 2)</p> <p>Aged-related changes in bladder function (2)</p> <p>Types of bladder diary (3,4,5)</p> <p>Systemic conditions affecting LUT</p> <p>Normal and abnormal diary patterns</p> <p>Influence of pharmacological agents</p>	<p>(1) http://kidney.NIDDK.NIH.gov/kudiseases/pubs/diary</p> <p>(2) 5th Int Consultation on Incontinence 2013</p> <p>(3) 5th Int Consultation on Incontinence 2013</p> <p>(4) CG171</p> <p>(5) Lifetec(CHECK ref for electronic diary)</p>	<p>lifetec</p> <p>www.NICE.org.uk</p>
Urinalysis	<p>Indications for MSU Culture</p> <p>Initiate appropriate antibiotic therapy (6)</p>	<p>Correct use of multistix/urinalysis machines (3)</p> <p>Infection control measures (4)</p> <p>Interpretation and actioning of results</p> <p>Red flag haematuria evidence based pathways (5)</p> <p>Local laboratory protocols for analysis of MSSU</p>	<p>(3) SfH CHS192</p> <p>(4) SfH IPC I&2</p> <p>(5) NICE CG 139(CHECK THIS), CG 171, CG97</p> <p>(6) SIGN 88 Management suspected urinary tract infection in adults</p>	<p>skillsforhealth.org.uk</p> <p>www.NICE.org.uk</p> <p>www.SIGN.ac.uk</p> <p>www.rcgp.org.uk/targetantibiotics</p>
Symptom & Quality of life Questionnaires	<p>Select appropriate questionnaire for patient population</p> <p>Application of scoring system and interpretation of scores</p> <p>Select tools to assess outcome of intervention</p>	<p>Generic & condition specific questionnaires (6)</p> <p>ICIQ</p> <p>BFLUTs</p> <p>I QoL</p> <p>SUIQQ</p> <p>UISS</p> <p>KHQ</p> <p>IPSS</p> <p>Electronic methods of administering questionnaires</p>	<p>(6) 5th Int Consultation on Incontinence 2013</p> <p>NICE CG 171</p> <p>NICE CG 97</p> <p>(7) Electronic Patient ePAQ</p>	<p>www.ICI.co.uk</p> <p>www.NICE.org.uk</p> <p>www.iciq.co.uk</p> <p>www.epaq.co.uk</p>

Types of Assessment tool	Skills to use	Knowledge base	Citation	Ref/access
Pad test	Application to clinical and research practice	Types of pad test (1 hour and 24hour), uses and limitations (8,9) Agents to colour urine	(8) 5th Int Consultation on Incontinence 2013 International Continence Society	www.ICI.co.uk www.ICS.org
Ultrasound assessment of residual urine	Ability to assess urinary residual volume	Types of bladder scanner (9) Ability to use equipment	(9) Health Improvement Scotland Evidence Note 32	www.healthcareimprovementScotland.org
Patient reported experience measure	Deliver patient-centred care	Understanding of patient journey, focus groups (10,11)	NHS Patient Experience Framework (10) Friends and family test (11) FIFE feeling, ideas, function expectation	www.gov.UK www.England.NHS.UK
Patient report outcome measures	Ability to relate goals to what is achievable	Professional standards (12,13) Expectations, Goal setting, Goal achievement, Satisfaction (EGGS) SAGA self assessment goal achievement	RCOG PROMs in gynaecology (12) NHS Guidance on Patient Reported outcome measures Brubaker and Schull, IUGJ 2005;16:171-173 Brubaker et al, IUGJ 2011;22:937-946 Khullar et al Neurourol Urodynamics 2013:	www.RCOG.org.uk http://www.hscic.gov.uk/proms

Types of Assessment tool	Skills to use	Knowledge base	Citation	Ref/access
Bowel assessment tools	<p>Ability to undertake assessment of bowel function</p> <p>Assessment of constipation</p> <p>Deliver patient centred care to patients with spinal injury</p>	<p>Tool to assist bowel care assessment and management</p> <p>Bristol Stool chart</p> <p>Rome Criteria</p> <p>Specific bowel assessment/management tools spinal injury patients</p>	<p>RCS Commissioning guide: faecal incontinence 2014 appendix 1</p> <p>Heaton.K.W., Radvan,J., Cripps,H., Mounfford, R.A., Braddon, F.E.M.,& Hughes, A.O., 1992. Defecation frequency and timing, and stool form in the general population a prospective study. Gut 33, 818-824</p> <p>Drossman D.A et al ., Senior editor Rome 111 The Functional Gastrointestinal Disorders. Degnon Associates INC 2006</p> <p>Multidisciplinary Association of Spinal Cord injury Professionals. (2012) Guidelines for Management of Neurogenic Bowel Dysfunction in individuals with Central/Neurological Conditions. www.mascip.co.uk/guidelines.aspx</p>	<p>www.bladderandbowelfoundation.org</p> <p>http://www.romecriteria.org/committees/ajg2011201a_SeverityPublished.pdf</p>

Service Evaluation Tools

There are many different service evaluation tools and measures available and the choice of tool will be dependent on need. We have outlined the various approaches. There are a series of questions that need to be answered to allow individuals to identify what methodology they would use to design or select a tool.

1. Whether this is a clinical evaluation or service review
2. Whether it is assessed against a predefined standard/benchmark
3. Which domains it is assessing against (Maxwell dimensions of health care quality)

Many simple standards are already described in the APPG Commissioning for Continence document and it is recommended to review these. If service improvement is a key then using QIPP framework may be appropriate. Patient engagement is usually of paramount importance and liaising with the CCG patient and public involvement team is advised.

It is important to ensure that Patient Reported Experience Measures are also recorded. A generic measure eg How are we doing or Friends and family test can be used.

References

- HQIP a guide for clinical audit and research and service review
- <http://www.bmj.com/content/bmj/288/6428/1470.full.pdf> (Maxwell's Domains)
- <http://www.rcplondon.ac.uk/resources/national-audit-continence-care>
- http://www.york.ac.uk/yhpho/documents/hea/Website/DOH_HEA_Guide%20for%20NHS.pdf
- <http://www.appgcontinence.org.uk/pdfs/CommissioningGuideWEB.pdf>
- <http://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx>
- CCG patient and public involvement team
- QIPP (framework) <https://www.evidence.nhs.uk/qipp> is a tool that can provide a framework for service change that may enable a service to meet these minimum standards

Maxwell's Dimensions of health care quality

- Access to services
- Relevance to need (for the whole community)
- Effectiveness (for individual patients)
- Equity (fairness)
- Social acceptability
- Efficiency and economy

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