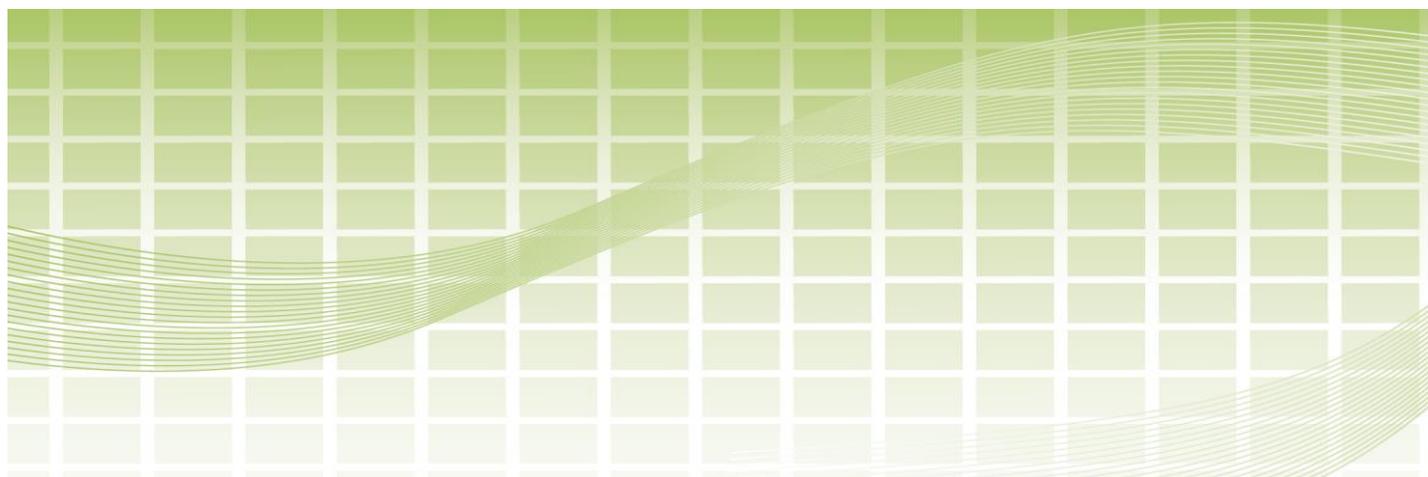


Guidance for the provision of absorbent pads for adult incontinence

A consensus document
2017



Royal College
of Nursing



**Association for
Continence Advice**

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Additional Circulation List	Bladder and Bowel Service Leads across England (although other countries may find the document useful)
Description	Consensus document regarding the provision of continence absorbent pads for adults, to ensure all adults who suffer with urinary or faecal incontinence, undergo a comprehensive assessment and have access to an equitable service
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1. Purpose

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

Best practice is where clinical assessment and personalised care planning is a fundamental activity prior to any provision of product, from the age of 18 years old. Transition for the child/young person to adult continence care should be underpinned by both the Child and Young Person consensus document (Bladder and Bowel UK 2016) and this document. The transition process needs to be robust and in conjunction with the local children's bladder/bowel (continence) service as described by the National Institute for Health and Care Excellence (NICE) <https://www.nice.org.uk/guidance/ng43>.

The document was produced through a consensus approach predominantly via membership of the Association for Continence Advice (ACA). Any conflicts of interests were managed and agreement reached via discussion.

Within England, although national guidance does exist (DH 2000), there is no statutory requirement for the provision of pads for incontinence, resulting in each health care trust and commissioning group (or health board or health and social care board), developing their own policy and guidelines. Consequently, the variation and discrepancy in access to provision has resulted in cost pressures and disproportionate distractions from best clinical practice. Clinical assessment is a critical component in the diagnosis of the underlying causes of incontinence, which should identify opportunities for treatment, before considering containment with pads, ensuring Covid-19 safety (<https://www.nhs.uk/conditions/coronavirus-covid-19/>).

1.1 Accountability

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

The clinician must also ensure the assessment for a suitable absorbent pad takes account of the environment(s). For example, the assessment should consider what would be suitable if the patient is soon to be transferring between care settings from

areas of high carer support to lower levels of carer support (such as on discharge from a hospital or nursing care setting, to their own home or supported living). The rationale is that a pad that may be deemed suitable in a facility where there is 24 hour nursing or carer support may not be suitable to meet the needs of that patient in the environment of their own home, where they may have little or no support.

2. Background

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

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

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

3. Current issues

Bladder and bowel problems are common and in most cases treatable, but they are poorly understood and under-prioritised within health and care provision in England (RCP 2010; Orrell et al 2013). Estimates of the burden of incontinence in England suggest that it affects up to 12.5 million people (ONS 2015).

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

Incontinence is a symptom, not a disease or diagnosis and has many possible causes as well as being only one of a range of other bladder or bowel symptoms. Urinary and faecal incontinence has been defined as ‘the complaint of any involuntary leakage of urine or faeces’ (Abrams et al 2002). Treatments are varied and it is therefore important to diagnose the cause(s) accurately. There is an increasing body of knowledge about the clinically effective treatments for most types of faecal and urinary incontinence, particularly through clinical guidance and quality standards, such as NICE and the Scottish Intercollegiate Guideline Network (SIGN) (NICE 2007, 2008, 2010, 2012, 2013, 2014, 2015, 2016 and 2017; SIGN 2012).

The impact of moderate symptoms on quality of life has been found to be similar to that of diabetes or high blood pressure, affecting a person’s independence, their

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

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

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

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

3.1 Use of containment products and intervention

- Treatment of incontinence will reduce reliance on pads and products as currently the number of individuals requiring a pad is increasing year on year (Wagg et al 2008).
- Providing and procuring in line with the procurement strategy, facilitating a cost-effective approach to purchasing continence pads (NHSE 2016).
- Treating overactive bladder syndrome in women produces Quality Adjusted Life Years (QALY's) gains and can reduce reliance upon containment products (Phillips et al 2015).
- Low cost community interventions e.g. lifestyle interventions, can cut pad usage by 50% (Imamura M et al 2010)
- Cost of pelvic floor interventions and bladder retraining is offset by a reduction in product usage (Demaagd and Davenport 2012; Borrie 2002)
- The multiprofessional approach to care should involve Occupational Therapy, Physiotherapy and other disciplines (such as Learning Disability or Mental Health Nurses) as required, as this can support individualised toileting programmes, support patients with functional incontinence and help to reduce

reliance on and costs of high absorbency containment products (Spencer et al 2017).

- Providing a mixture of devices and pads is preferred by users and reduces the number of pads used (Macaulay et al, 2014)

3.2 Infections

- Reducing the use of indwelling catheters can help to reduce catheter associated urinary tract infections (CAUTI'S) in combination with evaluation, education and training (NICE 2012; RCN 2018; Slyne et al 2012).
- Pressure ulcers and incontinence associated dermatitis is a national priority and identifying, assessing and treating continence issues can significantly reduce skin problems <http://nhs.stopthepressure.co.uk/>
- Urinary tract infections are prevalent especially in older women and untreated UTI's in men can lead to urinary retention <https://www.niddk.nih.gov/health-information/urologic-diseases/bladder-infection-uti-in-adults>
- Optimum symptom management can help to reduce infections (Shaw and Wagg 2017).

3.3 General Population and Care Home admission

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

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

4 Best practice statements for the provision of pads

This guidance assumes that clinical assessment and first-line treatment has taken place, and the patient has a clinical need for absorbent pad provision.

4.1 All care settings

1. Men and women should be treated equally in relation to absorbencies and product range available.
2. All adults with an identified continence problem must be offered a comprehensive bladder and/or bowel clinical assessment of their continence

condition, with appropriate identified interventions undertaken and reviewed. A positive response to the trigger question, "*Does your bladder or bowel ever/sometimes cause you problems?*" must lead to a comprehensive bladder and or bowel continence assessment.

3. For adults where it is known or anticipated there may be difficulties with maintaining bladder and/or bowel health e.g. learning disabilities, dementia or frailty, they should still have the opportunity for treatment before containment management options are implemented.
4. The registered healthcare professional remains responsible for the patients in their care; and for the clinical assessment of continence and instigation of first line treatment. The undertaking of a continence assessment can only be delegated to a non-registered healthcare professional who can demonstrate the necessary theoretical knowledge, skills and expertise, from Band 4 (Foundation Degree level e.g. Assistant Practitioner or Nurse Associate) upwards. Clear lines of accountability, responsibility and supervision by the registered healthcare professional who delegated the task must be in place.
5. Reassessment of product provision should be undertaken annually as a minimum. Patients should co-operate with reassessment and should they choose not to make themselves available or decline reassessment, then product provision via the NHS will be suspended or cease.
6. Individuals should self-fund absorbent pads until a clinical assessment has taken place. However, clinical assessment timescales (within referral to treatment time targets) should align with local commissioning arrangements.
7. Individuals (and healthcare professionals) could be encouraged to use the evidence-based and independent Continence Product Advisor website for product advice (www.continenceproductadvisor.org). This includes a validated patient decision aid to enable self-purchase/prescription of products and devices most suited to their needs.
8. Absorbent pads should not be supplied for treatable medical conditions (or for bodily fluids other than urine or faeces). The 'custom and practice' of automatically providing products to adults (including those with an acknowledged disability) is not appropriate and could be considered discriminatory. If an individual has capacity and declines treatment, provision of pads will not be offered as an alternative (an exception will be end of life).
9. Alternative collection devices should be considered for example, prescription urinals, urinary sheaths and body worn urinals, bags and adaptive underwear (e.g. specialist briefs with adapted collection systems).
10. The number of absorbent pads issued per 24 hours would normally not exceed 4, but provision should meet assessed clinical need. As part of the continence assessment process a validated scoring system should be in place to objectively measure "clinical need" in continence care (Howard-Thornton 2003). Pads

should be provided to meet patients' fundamental care needs, including maintaining independence (Murphy et al 2019)

11. Washable continence containment products should be available via the NHS for light (low volume) urinary incontinence. If clinically appropriate, items are also available on prescription such as urinary sheaths, body worn appliances or anal plugs. Small lower absorbency disposable pads are available from a variety of sources for self-purchase.
12. Use of a patient decision-aid (Murphy et al, 2020), which is specific to men post-radical prostatectomy, will help to identify products and devices that can be used along-side absorbent products. A decision-aid is incorporated into the continenceproductadvisor.org website, which may help.
13. Evaluation of the comparative effectiveness and acceptability of absorbent products should be made using a validated tool. The PadProm (Yearwood-Martin et al 2018) is an example of a tool and is part of the International Consultation on Incontinence suite of patient reported outcomes.
14. Where an individual presents with faecal loss only, a simple, rectangular pad should be recommended (super absorbent powder included in body of pad is not necessary).
15. The use of a two-piece system should be promoted where possible. For individuals where this isn't appropriate, the use of alternative styles may be necessary (Appendix 1). Wrap-around or pull-on products should be limited for patients who are able or capable of being toileted/using a toilet or for men with heavy incontinence, particularly at night (Fader et al, 2008) or where two-piece designs are not easily useable (e.g. for some people with dementia). Wrap-around or pull-on products should not be supplied to inpatients/care home patients where 24 hour care is available, unless toileting is clinically contra-indicated, and the pad has been authorised by the bladder and bowel nurse/Allied Health Professional specialist or the budget holder.
16. Individuals in receipt of absorbent pads should take enough supply when going on holiday or anticipated periods of time away from home.
17. Exceptions (e.g. not registered with a General Practice or clinical need beyond local guidance/policy) should be subject to a robust system that escalates cases to the local commissioner for consideration of additional funding on an individual case basis. Funding should follow the patient and any extra product cost accounted for.
18. Authorisation for bariatric products, maximum absorbency products e.g. over 1100mls, belted products and pull-on pants may be required from the continence nurse specialist or the budget holder.
19. Transition of children/young people into adult services should be cognisant of the need for continuation of continence care.

20. Transfers between service areas – if products or quantity differs and the patient has not had an updated clinical assessment within the last 6 months (that can be made available to the specialist bladder and bowel service in the area the patient has moved to), the patient will have to undergo a new clinical assessment; adhering to local provision until such time as an “exception/ outside of policy/above policy” case is made to the local commissioner for consideration.
21. Funding for absorbent pads should be kept separate from bladder and bowel clinical services. As product costs and quality data (for example product quality assurance, IT systems support and information governance, Registered Nurse Advisors, educational training and support, patient information, delivery and customer services) are commercially sensitive and should be available on a confidential need to know basis to the local commissioner and GP's when assessing or planning services to meet the overall health needs of their population.
22. Consideration of NHS procurement on a larger geographical footprint would reduce postcode lottery/variation when moving across regions.
23. Audit information from Home Delivery data collection and reporting systems should facilitate comparisons and benchmarking at national level.

4.2 Acute hospital inpatient care, Community Hospitals and Community Settings

24. Where an elective surgical procedure is anticipated; and it carries the potential risk of incontinence post operatively, the healthcare professional who is managing their care should consult with or refer the individual to the specialist bladder and bowel services prior to the operation (e.g. prostate surgery).
25. Absorbent pads will not be supplied before the individual person has undergone a comprehensive clinical assessment. Exceptions to this are for individuals at the end of life or for unplanned inpatient hospital admissions during the period of an acute illness, where a comprehensive clinical assessment is not possible. However, an assessment must be undertaken once an acute episode has stabilised. Assessment must be undertaken prior to discharge if incontinence is unresolved. Discharge from hospital must not be delayed for the patient with identified continence needs; an assessment must be made a priority issue prior to discharge.
26. During their hospital stay, all individuals with incontinence must have a continence assessment or reassessment completed and any first line treatment initiated (Table 1). Where a continence assessment has previously been performed, this information should be transferrable between settings and reviewed accordingly. In unresolved incontinence or in more complex cases, referral should be made to inpatient continence services if available. If incontinence has not resolved prior to discharge home, the hospital team must refer the patient for further clinical assessment on their return home. The hospital must have a robust discharge process in place to ensure individuals are

assessed by an accountable healthcare professional (refer to accountability in sections 1.1 and 4.1.4). An interim pad supply should continue until reassessed in the community setting, to ensure that the patient is not placed at immediate risk. Individuals may need to self-fund supplementary pads until a community continence assessment has taken place, which can be as long as 8 to 12 weeks.

Table 1

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

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

4.3 Care Homes (Nursing & Residential)

28. All care home residents, both nursing and residential (regardless of funding arrangements) should receive assessment, treatment and pads via the same NHS system to ensure quality and equity. Financial reimbursements are not

recommended and where this exists, the move to a provision system should be raised and managed between the local commissioner and the bladder and bowel service providers.

29. Care homes where residents are in receipt of absorbent pads via the NHS must co-operate with periodic audit by the NHS product provider to ensure efficient use of NHS funded products and resident's clinical needs are met. Furthermore, they should identify any staff training that may be required to support product use.
30. When a local commissioner provides funding for a person who requires residential care outside of their boundary that local commissioner will be responsible for the cost of any absorbent pads that maybe required by that person.

5. Recommendations

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

- A national standardised clinical assessment electronic template and scoring system (Howard-Thornton 2003) to be consistently available across the UK.
- Innovative models of continence care delivery to ensure patients do not continue to fall between the gaps of care sectors. Thus reducing the risk of falls, readmission, tissue viability issues and psychosocial distress.
- National non-branded patient information leaflet regarding NHS absorbent pad provision, with space so details of local continence services can be added.
- Public support networks - increased co-operation between NHS and voluntary sector to offer wider public support networks via independent charitable organisations such as Bladder and Bowel UK; and Age UK, etc.
- Options for absorbent pads to be incorporated within the personal budget system.
- Improved Care Quality Commission inspection of the quality of clinical assessment and treatments across all care settings.

6. References

Abrams P, Cardoza L, Fall M, Griffiths D, Rosier P, Ulmsten U, van Kerrebroeck P, Victor A & Wein A (2002) The Standardisation of Terminology of Lower Urinary Tract Function: Report from the Standardisation Sub-committee of the International Continence Society *Neurourology and Urodynamics* 21:167-178

APPG (2011) Cost-effective Commissioning For Continence Care. All Party Parliamentary Group For Continence Care Report. www.appgcontinence.org.uk

Bladder and Bowel UK (2016)
www.bladderandboweluk.co.uk

Borrie MJ et al (2002) Interventions led by nurse continence advisers in the management of urinary incontinence: a randomized controlled trial. *CMAJ*. 14;166(10):1267–1273

BGS (2016) Guidance on commissioning and providing healthcare services across the UK. British Geriatric Society
<https://britishgeriatricsociety.wordpress.com/tag/guidance-on-commissioning-and-providing-healthcare-services-across-the-uk-effective-healthcare-for-older-people-living-in-care-homes/>

Care England (2013)
<http://www.careengland.org.uk/sites/careengland/files/Care%20England%20CCG%20Continence%20FOI%20request%20report.pdf> Accessed on 17 August 2017

Continence Product Advisor (2017)
<https://www.continenceproductadvisor.org/products/pads>. Accessed on 15 August 2017

Fader M et al (2020) An International Continence Society (ICS) report on the terminology for single use bodyworn absorbent incontinence products Accepted for publication *Neurourology and Urodynamics*)

DH (2000) Good practice in continence services.
http://webarchive.nationalarchives.gov.uk/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005851

DH (2010) The Mid Staffordshire NHS Foundation Trust Inquiry: Francis report. Department of Health.
<http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffpublicinquiry.com/>

Expert Group on SIGN (2014) Who cares? Uncovering the incontinence taboo in social care. Astellas Pharma Ltd

Fader M, Cottenden A, Getliffe K, Gage H, Clarke-O'Neill S, Jamieson K, Green N, Williams P, Brooks R, Malone-Lee J. [Absorbent products for urinary/faecal incontinence: a comparative evaluation of key product designs.](#) Health Technol Assess. 2008 Jul;12(29):iii-iv, ix-185.

Fader M et al (2016) Continence Product Provision: Meeting patients' fundamental care needs. Policy Brief. University of Southampton

Macaulay M, Broadbridge J, Gage H, Williams P, Birch B, Moore KN, Cottenden A, Fader MJ. A trial of devices for urinary incontinence following treatment for prostate cancer. [BJU Int.](#) 2014 Dec 11

MHRA (2014) Devices in Practice: Checklists for using medical devices. Medicines and Healthcare products Regulatory Agency

HES (2012) <http://content.digital.nhs.uk/catalogue/PUB06335/hes-on-cons.pdf>
Hospital Episode Statistics; The Health and Social Care Information Centre

Howard-Thornton E.A. (2003) Dissertation: A comparative evaluation research study to compare the "expert" clinical opinion of qualified community continence nurses against results obtained using a "Continence Assessment Scoring Tool" (CAST); specifically designed to aid the assessment of "clinical need" in continence care within a Primary Health Care setting. Research & Ethics Department, Morecambe Bay Primary Care NHS Trust. Unpublished. For details please contact 01524 518581

Imamura M et al (2010) Systematic review and economic modelling of the effectiveness and cost-effectiveness of non-surgical treatments for women with stress urinary incontinence. Health Technol Assess 14(40):1- 188, iii-iv.

Leung FW & Schnelle JF (2008) Urinary and Fecal Incontinence in Nursing Home Residents. Gastroenterol Clin North Am. Sep; 37(3):697-707

Murphy C, de Laine C, Macaulay M & Fader M. (in press) Development and randomised controlled trial of a Continence Product Patient Decision Aid for men post-radical prostatectomy. Journal of Clinical Nursing.

Murphy C, de Laine C, Macaulay M & Fader M. (2019) Continence pad provision: Meeting patients' fundamental care needs. Nursing Times

NHSE (2018) Excellence in continence care: Practical guidance for commissioners, providers, health and social care staff and information for the public. NHS England

NHSE (2016) Our 2016/17 Business Plan. NHS England

NICE (2007) Faecal incontinence in adults: management Clinical Guidance 49. The National Institute for Health and Care Excellence

NICE (2017) Irritable bowel syndrome in adults: diagnosis and management Clinical Guidance 61. The National Institute for Health and Care Excellence

NICE (2015) Lower urinary tract symptoms in men Clinical Guidance 97. The National Institute for Health and Care Excellence

NICE (2010) Stroke in adults Quality Standard 2. The National Institute for Health and Care Excellence

NICE (2012) Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139. The National Institute for Health and Care Excellence

NICE (2012) Urinary incontinence in neurological disease: assessment and management Clinical Guidance 148. The National Institute for Health and Care Excellence

NICE (2013) Lower urinary tract symptoms in men Quality Standard 45. The National Institute for Health and Care Excellence

NICE (2013) Urinary incontinence: the management of urinary incontinence in women Clinical Guidance 171. The National Institute for Health and Care Excellence

NICE (2014) Faecal incontinence in adults Quality Standard 54. The National Institute for Health and Care Excellence

NICE (2015) Urinary incontinence in women Quality Standard 77. The National Institute for Health and Care Excellence

NICE (2015) Urinary tract infections in adults Quality Standard 90. The National Institute for Health and Care Excellence

NICE (2016) Irritable bowel syndrome in adults Quality Standard 114. The National Institute for Health and Care Excellence

NHS (2009) NHS-funded Nursing Care Practice Guide (revised) 2009. Department of Health

<http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Healthcare/IntegratedCare/NHSfundednursingcare/index.htm>

NHSE (2018) Excellence in Continence Care: Practical guidance for Commissioners, providers, health and social care staff and information for the public. National Health Service England <https://www.england.nhs.uk/publication/excellence-in-continence-care/>

ONS (2015) The estimate is based on calculating 23% of England's population (54.3 million). Data on populations taken from: Office of National Statistics, Population Estimates for UK, England and Wales, Scotland and Northern Ireland via:

http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/dcp171778_406922.pdf

Orrell A, McKee K, Dahlberg L, Gilhooly M and Parker S (2013) Improving continence services for older people from the service-providers' perspective: a qualitative interview study. *BMJ Open*; 3:e002926. doi:10.1136/bmjopen-2013-002926

Phillips V L, Bonakdar Tehrani A, Langmuir H, Goode P S, and Burgio K L (2015) Treating Urge Incontinence in Older Women: A Cost-Effective Investment in Quality-Adjusted Life-Years (QALY). *Journal of Geriatrics*, Article ID 703425

Rantell A, Dolan L, Bonner L, Knight S, Ramage C and Tooz-Hobson P (2016) Minimum Standards for Continence Care in the UK. *Neurourology and Urodynamics* 35:400–406

RCP (2010) Royal College of Physicians/HQIP, National audit of continence care: combined organisational and clinical report, September 2010
<https://www.rcplondon.ac.uk/projects/outputs/national-audit-continence-care-nacc>

RCN (2018) Catheter care: RCN guidance for nurses, Royal College of Nursing, London

Shaw C and Wagg A (2017) Urinary incontinence in older adults. *Medicine in Older Adults* Volume 45, Issue 1, Pages 23–27

Schluter P J, Ward C, Arnold E P, Scrase R, & Jamieson H A. (2017). Urinary incontinence, but not fecal incontinence, is a risk factor for admission to aged residential care of older persons in New Zealand. *Neurourology and urodynamics*, 36(6), 1588-1595.

SIGN (2012) Management of Bacterial Urinary Tract Infection Guideline 88. Scottish Intercollegiate Guideline Network. <http://www.sign.ac.uk/pdf/sign88.pdf>

Slyne H, Phillips C and Parkes J (2012) Saving Lives audits: do they improve infection prevention and control practice? *Journal of Infection Prevention* Vol 13 No 1

Spencer M, McManus K and Sabourin J (2017) Incontinence in older adults: The role of the geriatric multidisciplinary team. *British Columbia Medical Journal* Vol. 59 Issue 2, p99-105

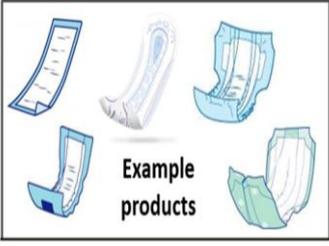
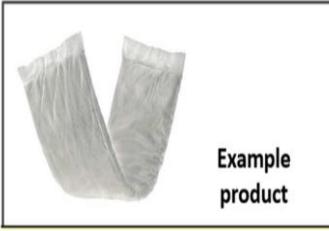
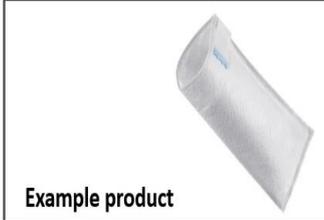
Wagg A, Potter J, Peel P, Irwin P, Lowe D and Pearson M (2008) National audit of continence care for older people: management of urinary incontinence. *Age and Ageing* 2008; 37: 39–44

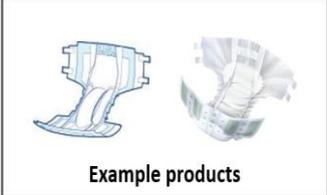
Yearwood Martin, C., Murphy, C., Cotterill, N., Williams, S., Cottenden, A. and Fader, M., 2018. Development and psychometric evaluation of ICIQ-PadPROM: A quality of life questionnaire to assess the treatment effect of absorbent continence products. *Neurourology and urodynamics*, 37(5), pp.1650-1657.

Yip S O, Dick M A, McPencow A M, Martin D K, Ciarleglio M M and Erekson E A. (2013). The association between urinary and fecal incontinence and social isolation in older women. American journal of obstetrics and gynecology, 208(2),146-e1.

Appendix 1

New terminology for single use bodyworn absorbent incontinence products

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

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

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