RCHT Continence Care Policy

V3.0

April 2015
### Summary

<table>
<thead>
<tr>
<th>Screening Question</th>
<th>This level is about improving access to continence care, which involves healthcare professionals encouraging discussion of the problem with patients and screen for it by asking:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Does your bladder or bowel ever/sometimes cause you problems?”</td>
</tr>
<tr>
<td></td>
<td>A positive response to the question requires completion of the screening tool.</td>
</tr>
<tr>
<td>Review of Reversible Factors using Screening Tool</td>
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</tr>
<tr>
<td></td>
<td>Where treatment to reverse any factor is unsuccessful and a continence problem continues to exist, referral onwards is required.</td>
</tr>
<tr>
<td>First Level</td>
<td>This level involves the healthcare professional who is competent at offering a first-level assessment using a locally approved clinical assessment tool.</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Second Level</td>
<td>This level includes specialists such as the Bladder and Bowel Specialist Service, Physiotherapists specialising in continence, Urologists, Gynaecologists and Eldercare Physicians</td>
</tr>
<tr>
<td></td>
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</tr>
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</tr>
</tbody>
</table>
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1. **Introduction**

1.1. This document sets out our organisational commitment for a high quality integrated continence service across Cornwall in partnership with commissioners and other health and social care partners.

1.2. Further context on priorities for high quality bowel and blacker care can drawn from The Francis Report (2010) which highlighted, in Mid Staffordshire NHS Trust, 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

Therefore this policy emphasises personalised assessment and care delivered by skilled staff across organisational and professional boundaries and reinforces our dignity in care commitment.

1.3. This version supersedes any previous versions of this document.

2. **Purpose of this Policy/Procedure**

2.1. The purpose of this policy is to define the clinical and professional expectations for continence promotion and care in Cornwall.

2.2. The document mirrors that of Cornwall-wide NHS partners, but contains local Royal Cornwall Hospital NHS Trust reference to promote excellence in continence promotion and care in our hospitals that put dignity in care at the heart of service we deliver.

3. **Scope**

3.1. This policy applies to all Trust staff who are directly or indirectly involved in the care of people with continence problems, their carers and families where applicable.

4. **Definitions / Glossary**

4.1. Continence care: is ‘the total package tailored to meet the individual needs of patients with bladder and bowel problems’ (DH 2010).

4.2. 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 incontinence has been defined as ‘the complaint of any involuntary leakage of urine’ (Abrams et al 2002). Treatments are varied and it is therefore important to diagnose the cause(s) accurately.

4.3. For further definitions of signs and symptoms, please refer to the standardisation documents at www.icsoffice.org

5. **Ownership and Responsibilities**

5.1. The Chief Executive and wider Trust Board have key roles and responsibilities to
ensure the Trust meets requirements set out by statutory and regulatory authorities (for example: the Department of Health, Commissioners and the Care Quality Commission). These responsibilities are delegated to an Executive Lead with supportive structures to ensure and assure standards and expectations are met. These are described below:

5.2. **Role of the Executive Lead**
The Executive Director for Nursing, Midwifery and Allied Health Professional is the nominated Executive Lead and will be responsible for ensuring structures and processes are in place to assure delivery of the organisation’s commitment to an integrated continence service. The Executive Lead will report to Trust Board on progress as required.

5.3. **Role of the RCHT Virtual Continence Action Group Members**
The Virtual Action Group is made up of two distinct participative groups: subject specialist and divisional representatives

- **Subject specialist**: bring expertise of the subject, from clinical, managerial and commissioning perspectives

- **Divisional representative**: are fundamental to ensure work flows from the action group to clinical teams and that a feedback mechanism is established back to the action group

The Virtual Action Group is responsible for delivering the clinical and corporate requirements linked to the highest standards of continence care; and the ownership and delivery of a local improvement agenda. This Group reports on request to the RCHT Governance Committee.

5.4. **Role of the RCHT Governance Committee**
The RCHT Governance Committee will hold to account the work and actions of the RCHT Virtual Continence Care Action Group. It will receive and scrutinise progress in delivering any local improvement plan on behalf of the Trust Board.

5.5. **Role of Divisional Management Teams**
Divisional Management Teams (Divisional Director, Divisional General Manager and Divisional Nurse) are responsible for ensuring their divisional representative are helping to driving up the standards of care. Effective mechanism for communication and dissemination of information to all clinical teams must be assured.

5.6. **Role of Ward and Department Sisters and Charge Nurses (and other Departmental Leads / Managers)**
Line managers are responsible for in driving through changes and to ensure effective communication channels exist to the divisional representative encouraging dissemination of information and actions across the wider health care team.

5.7. **Role of Individual Staff**
All staff members are responsible to ensure they comply with Trust policy regarding continence care. They must meet requirements set out regarding learning and development for their level of involvement with people with continence problems and should ensure they know who their local divisional representative is to enable communication and sharing of information.

6. **Standards and Practice**

6.1. **The Context of Cornwall’s Integrated Continence Service: Philosophy**
6.1.1. A person has the right to be continent, whenever this is achievable and to the highest standards of available health care, social care and management to ensure an optimum quality of life, independence and personal dignity (Privacy and Dignity 2009; RCP 2011).

6.1.2. **Key Role for the Healthcare Professional**
- Seek to identify early the continence status of the patient
- Activate a first-level assessment where bladder and/or bowel continence dysfunction is identified
- Participate in education to increase knowledge and skill
- Take action to preserve and maximise privacy and dignity
- Comply with clinical care pathways
- Demonstrate a caring attitude

6.1.3. **Key Role for the Bladder and Bowel Specialist Service**
- Provide advanced second level assessment to patients in the treatment and management of faecal and/or urinary incontinence
- Act as a resource for healthcare professionals in the pursuit of therapeutic continence care delivery
- Develop collaborative clinical practice guidelines using evidence based practices and pathways of care; ensuring that they are implemented, regularly updated and available to relevant staff
- Monitor quality through clinical audit, taking into account comments and complaints
- Work in partnership with other organisations (NHS Trusts/PCT; other statutory and voluntary organisations)
- Provide educational support and training programmes to the multidisciplinary team
- Deliver high quality and cost effective services.
- Provide a link/support network of ‘Continence Link Nurses’
- Hold current literature on the promotion of continence and management of incontinence.

6.1.4. **Treatment of Incontinence and Related Symptoms**
There is an increasing body of knowledge on the clinically effective treatments for most types of faecal and urinary incontinence (NICE 2006; SIGN 2004; NICE 2007; NICE 2010). Much research is in progress and the Bladder and Bowel Specialist Service will assist in keeping healthcare professionals up-to-date or use its national and international contacts to seek information as necessary.

6.1.5. **Organisation of Care**
Continence problems will largely be identified and assessed for in primary and community care settings. However, some people will present for the first time during a hospital admission (acute and community) and therefore healthcare professionals must be competent to carry out a first level clinical assessment.

Treatment and support for the patient will be offered at the following levels of care:
### Screening Question

This level is about improving access to continence care, which involves healthcare professionals encouraging discussion of the problem with patients and screen for it by asking: “Does your bladder or bowel ever/sometimes cause you problems?” (Essence of Care 2010)

A positive response to the question requires completion of the screening tool.

### Review of Reversible Factors using Screening Tool

An RCHT Continence Screening Tool should be used to eliminate any factor which could reverse the continence problems.

Where treatment to reverse any factor is unsuccessful and a continence problem continues to exist, referral onwards is required.

### First Level

This level involves the healthcare professional who is competent at offering a first-level assessment using a locally approved clinical assessment tool.

Failure of treatment or doubtful diagnosis will determine referral to the second level.

### Second Level

This level includes specialists such as the Bladder and Bowel Specialist Service, Physiotherapists specialising in continence, Urologists, Gynaecologists and Eldercare Physicians

Referral onto the third level will be for complex cases not resolved at this level.

### Third Level

This level is a further step for highly specialised care, usually provided in centres of excellence.

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6.1.6. **Professional Accountability**

Clinical decision-making should be enhanced by professionally recognised or evidence based practice. Adopting this means accepting responsibility for the patient, while being able to justify those decisions to patients and peers. Healthcare professionals should ensure that they are adequately prepared to undertake clinical assessments if it is within their scope of practice (NMC 2008). Opportunities for role redesign will be considered to sustain and improve healthcare provision.

6.1.7. **Indwelling Urinary Catheterisations**

- Indwelling urinary catheterisation should be avoided wherever possible. Staff should refer to the RCHT Catheter Policy for any catheterisations planned to be undertaken. Agreed local
documentation tools should be used i.e. the catheter care plan with insertion record.

- All staff should have completed local training before attempting catheterisation procedures. Non-medical healthcare professionals should not insert the first catheter via the urethra for patients where there is a known bladder or prostate cancer, recent pelvic surgery or injury, or significant haematuria. Subsequent catheterisations for such patients may need to be performed within a controlled environment. For all other patients, it will be the clinical judgment of the assessing healthcare professional to determine whether or not it is safe to perform a first-time male or female urethral catheterisation. Supra-pubic urinary catheters are initially inserted within secondary care. Subsequent supra-pubic catheter changes can be performed in community settings by competent healthcare professionals as and when it is safe to do so.

6.1.8. First Level Assessment

Individuals with bladder or bowel dysfunction will be assessed with skill and sensitivity. The key aims of assessment are to establish:

- The cause of the symptoms
- What is required in terms of further investigation or treatment
- How these objectives can be achieved
- How to help the patient to achieve the best quality of life

Assessments will include:

- History
- Patient goals and expectation of treatment
- Physical examination
- Bladder diary
- Urinalysis
- Post-void urine measurement

Conservative treatment measures will include:

- Behavioural and lifestyle modifications
- Pelvic floor exercises
- Bladder retraining
- Medication
- Devices/products

A treatment/management plan should be agreed with the patient and a copy given to them (DH 2000).

6.1.9. First Level Reassessment

Patients/clients will be reviewed or reassessed depending on their individual need, taking into account treatment, management and plan of care. On-going reassessment will be documented for each individual patient/client. This will include any changes in symptoms. Reassessment dates must be documented in the patient’s notes. The contact number of the assessing clinician will be available to the patient/client and carer.

6.1.10. Absorbent Hygiene Products
• **For acute hospital patients** pad use is based on individual assessment and selection of the right product, if required. Each ward stock a core range and other products are available within each division to ensure individually assessed and fitting products are available.

• Pad use should only be based on holistic assessment (clearly documented) and will often be supported by incontinence screening assessment.

• Under no circumstances are ‘procedural sheets’ or ‘bed squares’ to be used to deal with incontinence – use reflects unacceptably poor practice and/or un-confidence with the healthcare professionals assessment and product selection, in which case senior support and advise should be sort.

• Consideration in using the patients own absorbent hygiene products in hospital, if supplied by the NHS, are encouraged - to maintain continuity of care.

• If pad use is recommended on discharge communication to the district nursing service is essential.

• **For community based patients** prescription of a product is made by the assessing healthcare professional following a first level assessment using a locally approved clinical assessment tool. No product should be prescribed for a patient without a first level clinical assessment. Should a patient/client refuse an assessment and/or treatment then the community service provider will have to reach local/individual agreement about provision of products.

• It is important to acknowledge quality of life and cost-effectiveness rather than cost alone. Clinical need should determine the type and number of products to be allocated per 24 hours. However, in the community, authorisation is required by a team leader before the requisition of a product is activated, if the number within a 24-hour period exceeds 4 (from the age of 4 years upwards).

• It is recommended that reassessment takes place six monthly for those receiving long-term supplies. This is to check that clinical needs have not changed or that there is not a newer product available that may be more suitable.

• For patients with life-threatening disease and where end-of-life care is being delivered, enough products should be provided to maximise comfort and dignity. Products can be delivered as an urgent order providing they are authorised by the Community Team Leader.

### 6.1.11. Admission to Hospital

• For emergency admissions to secondary care, the assessing healthcare professional should do a screening level assessment, which should be documented and appropriate action taken (see 3.5).

• Secondary screening using the RCHT Incontinence Screening Tool should be used to either prompt further referral for assessment by a medical practitioner or to start exploring reversible factors for action.

• Should continence symptoms become apparent during an in-patient stay, then a reversible factor screening should be
commenced before, if necessary, moving on to any first level assessment.

- The care plans for faecal and urinary incontinence should be completed as clinically required: CHA 2931 (faecal incontinence) and CHA 2930 (urinary incontinence).
- Community nurses should liaise with secondary care where hospital admission is known. Suspension of a pad delivery may need to be considered.
- The use of products within hospital should be preceded by an individual clinical assessment to ensure optimum and safe use of body-worn products.
- The use of bed squares are not recommended for the management of incontinence.

6.1.12. Discharge from Hospital
Key information needs to be passed onto community nurses or care homes which include:

- Copy of any reversible factor screening or first-level assessment and management plan (e.g. catheter insertion record).
- Referral onto Second and Third levels as required.
- Any equipment and level of supply (for example, specific details of urethral, supra-pubic or clean intermittent catheterisation; 7 days supply of body worn pads and catheter urine drainage /collection systems).
- Patients with long term catheters inserted in hospital should leave with a 'My Urinary Catheter Passport', available from hospital guardian boxes.
- Any other appropriate information.

6.1.13. Delivering the Integrated Continence Service

- The commissioning of services will be the responsibility of the NHS Cornwall and Isles of Scilly / Kernow Clinical Commissioning Group ensuring that there is a fully integrated service providing seamless care for individual patients within health and social care settings (DH 2001; APPG 2011).
- The Bladder and Bowel Specialist Service will continue to improve the quality of service.
- Relationships with primary and secondary care, Department of Adult Social Care, Department for Children, Young People and Families and the independent sector will be maintained, based on a principle of integrated care wherever the patient is situated.

6.1.14. Training and Support

- Each primary, community and hospital team should have the necessary skills to be able to undertake a screening and first level assessment.
- All registered healthcare professionals with the responsibility for first level clinical assessment and support workers who contribute to continence care must have received educational preparation. To help equip and prepare staff, they can access local study days and
the University Partnership module HEAC348 ‘Effective Promotion of Continence and Management of Incontinence’.

- Local study days for clinicians and support workers may include:
  - Bladder Dysfunction in the Adult
  - Bowel Dysfunction in the Adult
  - Developing Competence in Catheterisation
  - Intermittent Self-Catheterisation

7. Dissemination and Implementation

7.1. This policy will be cascaded by the RCHT Continence Care Action Group to Divisional Representatives for communicating and sharing at a local clinical level, making all resources available to all relevant staff.

7.2. This policy’s implementation will be through the delivery of the improvement plan for continence care, championed by the Action Group. This promotes training and educational opportunities and makes sure local recourses are available via divisional representatives.

8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>This policy underpins the Trust commitment to improve the continence care across our services. National standards are established (reflected in this Policy) and an improvement framework exists to drive up standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead(s)</td>
<td>The Trust’s ‘Clinical Continence Lead’ takes responsibility for monitoring (auditing) the Trust’s clinical performance in meeting the nationally set standards of care and service delivery for continence care. The Trust Strategic Lead for Continence Care take responsibility for monitoring (auditing) the Trusts’ operational and strategic performance against nationally set standards for continence care in hospital.</td>
</tr>
<tr>
<td>Tool</td>
<td>The Trust is committed to participating in the National Continence Care Audit, conducted by the Department of Health and facilitated by the Royal College of Physicians. This template is nationally negotiated and published.</td>
</tr>
<tr>
<td>Frequency</td>
<td>The Trust’s clinical care performance is benchmarked with National results. These are published and reported, currently on an bi-annual basis (each two years).</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The Trust’s performance report, local response and improvement plan are presented through the RCHT Continence Care Action Group to the RCHT Governance Committee, who act on behalf on the Trust Board to scrutinise and monitor improvement delivery.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The RCHT Continence Care Action Group leads on service improvement for bowel and bladder care in the organisation. It is tasked to deliver the improvement plan developed form audit and self assessment against the national standards.</td>
</tr>
<tr>
<td>Change in practice and lessons to be</td>
<td>Improvement and change in service delivery is documented in the notes and minutes of the Action Group, any sub groups and in the evidence folders linked to the hospital standards.</td>
</tr>
</tbody>
</table>
9. **Updating and Review**

9.1. The policy will be kept under review by the authors and RCHT Continence Care Action Group in line with Trust strategic and operational developments and clinical practice changes. The minimum review period will be in three years time in line with Trust policy. Revision activity is recorded in the version control table at the beginning of this document.

10. **Equality and Diversity**

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

10.2. Royal Cornwall Hospitals NHS Trust is committed to a Policy of Equal Opportunities in employment. The aim of this policy is to ensure that no job applicant or employee receives less favourable treatment because of their race, colour, nationality, ethnic or national origin, or on the grounds of their age, gender, gender reassignment, marital status, domestic circumstances, disability, HIV status, sexual orientation, religion, belief, political affiliation or trade union membership, social or employment status or is disadvantaged by conditions or requirements which are not justified by the job to be done. This policy concerns all aspects of employment for existing staff and potential employees.

10.3. **Equality Impact Assessment**

10.3.1. The Initial Equality Impact Assessment Screening Form is at Appendix 2.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>RCHT Continence Care Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>30th April 2015</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>30th April 2015</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>29th April 2018</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Frazer Underwood, Consultant Nurse / Associate Director of Nursing</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 255043</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>The purpose of this policy is to ensure the Trust meets strategic and clinical best practice standards in delivering its ambition to provide excellent continence care services.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Continence; Continence Promotion; Continence Care; Incontinence; Continence Management</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT ✔ PCH CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Andrew MacCallum, Interim Nurse Executive</td>
</tr>
<tr>
<td>Date revised:</td>
<td>April 2015</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>RCHT Continence Care Policy V2.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>RCHT Continence Care Action Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Frazer Underwood, Consultant Nurse / Associate Director of Nursing</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: Frazer Underwood, Consultant Nurse / Associate Director of Nursing</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet ✔ Intranet Only</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / General</td>
</tr>
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</table>
## Links to key external standards

<table>
<thead>
<tr>
<th>CQC Outcomes: 1, 2, 4, 5, 6, 7, 9</th>
</tr>
</thead>
</table>

- RCHT Infection Control Policy
- RCHT Dignity in Care Policy
- RCHT Chaperoning Guidelines
- RCHT Urinary Catheterisation in Adults Policy
- Royal Marsden Hospital Manual of Clinical Nursing Procedures (7th Edition)
- Department of Health (2000) Good practice in continence services
- Department of Health (2010) Essence of Care: Patient-focused benchmarking for health care practitioners
- Department of Health (2001) National Service Framework for Older People
- Privacy and Dignity in Continence Care Project: (2009) Attributes of dignified bladder and bowel care in hospital and care homes Phase 1 & 2 Reports; University of Kent, Royal College of Physicians & British Geriatric Society
- Royal College of Physicians (2011) Keeping control: what you should expect from your bladder and bowel service (based on findings from the national audit of continence care 2010)

Edinburgh SIGN

Training Need Identified? Yes

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>01 May 10</td>
<td>V1.0</td>
<td>Initial issue</td>
<td>Frazer Underwood – Chief Divisional Nurse (Medicine)</td>
</tr>
<tr>
<td>31 Oct 12</td>
<td>V2.0</td>
<td>Biannual review; Uploaded into new policy template and only minor changes made.</td>
<td>Frazer Underwood – Consultant Nurse/Associate Director of Nursing</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

### Name of service, strategy, policy or project (hereafter referred to as *policy*) to be assessed:
RCHT Continence Care Policy

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Directorate and service area:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Policy</td>
<td>Corporate Policy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of individual completing assessment:</th>
<th>Name of individual completing assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frazer Underwood</td>
<td>Frazer Underwood</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Is this a new or existing Procedure?</th>
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<tbody>
<tr>
<td>Existing</td>
<td>Existing</td>
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<table>
<thead>
<tr>
<th>Telephone:</th>
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<tr>
<td>01872 255043</td>
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<tr>
<th>Policy Aim*</th>
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<tbody>
<tr>
<td>The purpose of this policy is to ensure the Trust meets strategic and clinical best practice standards in delivering its ambition to provide excellent continence care services.</td>
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</table>

### 2. Policy Objectives*

<table>
<thead>
<tr>
<th>Improve and standardise care</th>
<th>Improve and standardise care</th>
</tr>
</thead>
</table>

### 3. Policy – intended Outcomes*

<table>
<thead>
<tr>
<th>Improved patient and carer experience of continence care in hospital</th>
<th>Improved patient and carer experience of continence care in hospital</th>
</tr>
</thead>
</table>

### 4. How will you measure the outcome?

<table>
<thead>
<tr>
<th>Bi-annual participation in the National Continence Care Audit</th>
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</tr>
</thead>
</table>

### 5. Who is intended to benefit from the Policy?

<table>
<thead>
<tr>
<th>Patient, carers and staff</th>
<th>Patient, carers and staff</th>
</tr>
</thead>
</table>

### 6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?

<table>
<thead>
<tr>
<th>No</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>b. If yes, have these groups been consulted?</th>
<th>b. If yes, have these groups been consulted?</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. Please list any groups who have been consulted about this procedure.</td>
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</tr>
</tbody>
</table>

### 7. The Impact

Please complete the following table.

<table>
<thead>
<tr>
<th>Are there concerns that the policy <em>could</em> have differential impact on:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality Strands:</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Age</td>
</tr>
</tbody>
</table>
You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation—this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. | Yes | No ✓

9. If you are not recommending a Full Impact assessment please explain why.

Promoting very best practice, nothing unexpected or unusual in this policy requirements.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frazer Underwood</td>
<td>30th April 2015</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
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<tbody>
<tr>
<td>1.</td>
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<tr>
<td>2.</td>
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Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed Frazer Underwood

Date 30th April 2015