

# Guidance for the provision of absorbent pads for adult incontinence

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A consensus document  
2021



Royal College  
of Nursing



**Association for  
Continence Advice**

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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 must be underpinned by both the Child and Young Person consensus document (Bladder & 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 developing their own policy and guidelines. Consequently, the variation and discrepancy in access to provision has resulted in lack of equal access to care and disproportionate distractions from best clinical practice. Clinical assessment is a critical component in the diagnosis of the underlying causes of incontinence, which must identify opportunities for treatment, before considering containment with pads.

### 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 must be advised on how to apply/use the product and be given sufficient information and training in the safe use of the product.

The clinician must also ensure the assessment for a suitable absorbent pad takes account of the environment(s); and ensuring Covid-19 safety (<https://www.nhs.uk/conditions/coronavirus-covid-19/>). For example, the assessment must consider what would be suitable if the patient is soon to be transferring between care settings from areas of high carer support to lower levels of carer support (such as on discharge from a hospital or nursing care setting, to their own home or supported living). 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 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, but it also contributes to unnecessary costs to the NHS through avoidable complications such as infections, pressure ulcers and falls, which can increase the amount of time spent in high-cost hospital settings as detailed by the Expert Group on Lower Urinary 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 must involve Occupational Therapy, Physiotherapy and other disciplines (such as Learning Disability or Mental Health Nurses) as required, as this can support individualised toileting programmes, support patients with functional incontinence and help to reduce reliance on and costs of high absorbency containment products (Spencer et al 2017).

- Providing a mixture of devices and 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 must 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 within 18 weeks of referral (or as per locally agreed referral to treatment times). A positive response to the trigger question, "*Does your bladder*

*or bowel ever/sometimes cause you problems?"* must lead to a comprehensive 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 must still have the opportunity for treatment before containment management options are implemented.
4. The registered healthcare professional remains responsible for the patients in their care; and for the clinical assessment of continence and instigation of first line treatment. The undertaking of a continence assessment can only be delegated to a non-registered healthcare professional who can demonstrate the necessary theoretical knowledge, skills and expertise, from Band 4 (Foundation Degree level e.g., Assistant Practitioner or Nurse Associate) upwards. Clear lines of accountability, responsibility and supervision by the registered healthcare professional who delegated the task must be in place.
5. Reassessment of bladder and bowel health; and product provision must be undertaken annually as a minimum. Patients must be encouraged to co-operate with reassessment and should they choose not to make themselves available or decline reassessment, then product provision via the NHS will be suspended or cease.
6. Individuals must be encouraged to self-fund absorbent pads until a clinical assessment has taken place. However, clinical assessment timescales (within referral to treatment time targets e.g., 18 weeks) must align with local commissioning arrangements.
7. Individuals (and healthcare professionals) could be encouraged to use the evidence-based and independent Continence Product Advisor website for product advice ([www.continenceproductadvisor.org](http://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 shouldn't 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 must be considered for example, prescription urinals, urinary sheaths and body worn urinals, bags and adaptive underwear (e.g., specialist briefs with adapted collection systems).
10. The number of absorbent pads issued per 24 hours would normally not exceed 4, but provision must 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 must

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

11. Washable continence containment products must be available via the NHS for urinary incontinence. 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 must be promoted where possible. For individuals where this isn't appropriate, the use of alternative styles may be necessary (Appendix 1). Belted, wrap-around, or pull-on products must 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). Belted, 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 (e.g., hospital admission).
17. Exceptions (e.g., not registered with a General Practice or clinical need beyond local guidance/policy) must be subject to a robust system that escalates cases to the local commissioner for consideration of additional funding on an individual case basis. Funding must 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 must be cognisant of the need for continuation of continence care. Reassessment of clinical need (not just

historic provision) must be conducted within six-months of transition and thereafter annually.

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. Product costs and quality data 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.

#### 4.2 Acute hospital inpatient care, Community Hospitals and Community Settings

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

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

25. Inpatient services must 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)**

26. All care home residents, both nursing and residential (regardless of funding arrangements) must 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 must be raised and managed between the local commissioner and the bladder and bowel service providers.

27. 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, any staff training must be identified that may be required to support product use.

28. 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 & 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.
- Consideration of NHS procurement on a larger geographical footprint would reduce postcode lottery/variation when moving across regions.
- Audit information from Home Delivery data collection and reporting systems must facilitate comparisons and benchmarking at national level.

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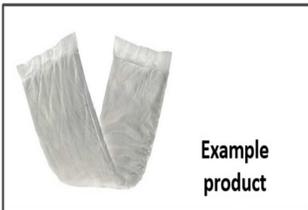
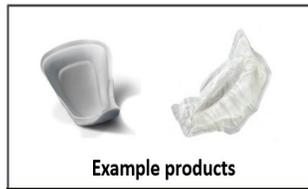
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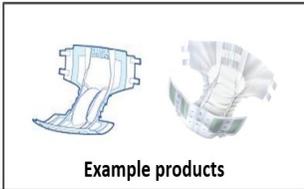
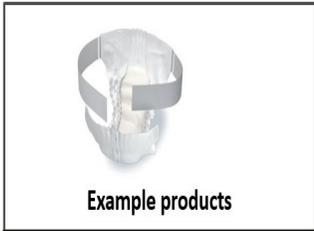
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## Appendix 1

### 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>Example products</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>Example product</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>Example products</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>Example product</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>Example products</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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