Specialist Community Nursing Services

Continence Education and Consumables Services

Tier 3 Service Specification

September 2024

Health New Zealand
Te Whatu Ora

Contents

1. Status

Approved to be used for mandatory nationwide description of services to be provided.

MANDATORY ☑ RECOMMENDED ☒

It is compulsory to use this Specification when purchasing services. No Districts should use a local service specification instead of this mandatory specification.

2. Review History

Review History	Date
Published on NSFL	November 2012
Review: of Continence Services (June 2003) service updated all content.	17 September 2012
Content moved to updated Health New Zealand format	September 2024
Consideration for next service specification review	Within the next 5 Years

Note: In September 2024 a small programme of work moved all Service Specifications to Health New Zealand branded templates. No amendments were made to the body text or content of the Service Specification, so references to DHB, Ministry of Health or other pre-2022 reforms vocabulary will still exist. A larger programme of work to review and revise all Service Specifications is planned for late 2024 to early 2025.

Note: Contact the Service Specification Programme Manager, National Health Board Business Unit, to discuss the process and guidance available in developing new or updating and revising existing service specifications. Web site address Nationwide Service Framework Library: Nationwide Service Framework Library – Health New Zealand

3. Introduction

The overarching Tier One Community Health, Transitional and Support Services specification contains generic principles and content common to all the tiers of specifications below it.

This Tier Three service specification for Continence Education and Consumables Services (the Service) must be used in conjunction with either the Tier Two Specialist Community Nursing Services, or the Allied Health (Non Inpatient) service specification as appropriate, and the Tier One Community Health, Transitional and Support Services service specification, or as age appropriate, the Tier One Services for Children and Young People service specification.

It is also linked to the Tier Three Stomal Therapy Services service specification and the Tier Two Urology and Tier Two Gynaecology Services service specifications of the suite of Specialist Medical and Surgical service specifications.

Refer to the Tier One Community Health, Transitional and Support Services service specification sections for generic details on:

- Service Objectives
- Service Users
- Access
- Service Components
- Service Linkages
- Exclusions
- Quality Requirements

The above sections are applicable to all Service delivery.

4. Service Definition

This Service is for those Eligible[1] people, four years of age or over, who meet the access criteria and have a demonstrated urinary and / or faecal incontinence.

The supply of Continence Consumables will be determined using agreed appropriate assessment tools[2] in collaboration with the Service User and their family and / or whanau member. The equipment and continence aids may be provided as assessed by a Continence Advisor[3].

This Service supports Service Users remaining in their own community by providing continence services in the Service User's own home or other appropriate setting, if the Service User's health needs can be appropriately managed in the community in a cost-effective manner.

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[1] Not all Service Users who are referred or present to the Service are eligible for publicly funded services. The eligibility criteria for publicly funded health and disability services are prescribed by Ministerial Direction. Refer to http://www.moh.govt.nz/eligibility for information on the latest eligibility criteria.

[2] A range of DHB and Nurse Maud Continence Assessment tools are available on the NSFL website.

[3] For the purposes of this service specification, a Continence Advisor includes a Registered Nurse or delegated health professional with the skills to complete the continence assessment.

5. Service objectives

5.1 General

The objective of the Service is to maximise the Service User's self-management, independence and quality of life to minimise the health complications which could arise from incontinence.

5.2 Māori Health

Refer to the Tier One Community Health, Transitional and Support Services service specification.

6. Service Users

The Service Users are those Eligible people who, have been assessed as needing the Service and are expected to need long term continence services (for six months or more).. This includes people with a disability.

Where the Service User is already under the care of this Service before entering palliative care community services, the Service will continue to provide supplies.

7. Access

7.1 Referral Process for Service Provision

The assessed health status risk will guide the determination of entry to service and the priority for entry and will form the basis for discharge from the Service. (See Appendix 1 for the Risk Assessment Framework).

A person may be referred to the Service, by an appropriate health professional, if they have a demonstrated urinary and / or faecal incontinence that affects daily living, places them at risk of deterioration in health status and is not consistent with normal development and this problem may be appropriately managed in the community.

Service Users are eligible for the Service on referral from:

- a General Practitioner (GP), Nurse Practitioner, or other appropriate health professional, if the Service User has a minimum of a three month history of on-going continence problems that is not responsive to other treatment for the continence problem
- a medical or surgical specialist for an acute incontinence problem associated with the Service User's medical or surgical condition
- a surgical specialist or specialist nurse for a Service User with a stoma or urinary diversion requiring on-going supply of appropriate continence consumables
- self- if the person meets the eligibility criteria for prescribed Continence Consumables. Such a referral will only result in service provision (and specifically the supply of Continence Consumables) where the person meets the Eligibility for Continence Consumables, see section 7.1.1 below.

7.1.1 Eligibility for Continence Consumables

The degree of incontinence experienced by the Service User is assessed by a Continence Advisor, using appropriate Continence Assessment tools[4]. Continence Consumables may be prescribed by a Continence Advisor, following assessment of the Service User and an active treatment programme, based on the degree of incontinence. The Continence Consumables Guidelines, see Appendix Two, may be varied for individual cases according to clinical discretion.

Eligibility for the provision of a prescribed range of Continence Consumables is where the Service User is:

- a child aged between 4 and 10 years old who is living in their own home (including Child Youth and Family residences or other such care), who has an incontinence problem that is inconsistent with normal development, is represented by a urinary incontinence problem greater than 50 mls per episode and more than 4 times a day, and / or has a problem with bowel control
- over the age of 10 years old and has a urinary incontinence problem with a loss of at least 400mls over 24 hours and / or has a problem with bowel control.
- a resident of a Residential Home / Care Facility[5]. These residents are eligible for specialist assessment, advice, support and Continence Consumables under the same criteria as a person living in their own home.[6]

A person resident in a certified Age Related Residential Care (ARRC) facility is eligible, under this service specification, for specialist continence assessment and advice. Continence Consumables that are of an appropriate standard to meet the assessed needs of residents, as set out in the resident's Care Plan, are the responsibility of the ARRC provider. Exclusions may include people who are resident for short term care where Continence Consumables are not covered by the ARRC agreement, or other funder agreements. This may include Residential Care provided under short term arrangements such as Carer Support, respite care, Primary Options for Acute Care (POAC) or Interim Care.

7.1.2 Travelling Service Users

Travellers within New Zealand, who are prescribed continence consumables, must check with their local service for their need for consumable supplies when planning their travel outside their District of domicile. Districts must use the current Operational Policy Framework guidelines in determining a person's usual residence for the purposes of the Inter District Flow rules. [7]

The service provider of the District of the Service User's Residence is responsible for providing travellers with:

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[4] DHB and Nurse Maud Continence Assessment Tools are available on the NSFL website.

[5] Residential Home / Care facilities: includes rest homes, and contracted facilities that provide 'housing and recovery services' or 'community support services with accommodation' for mental health and addiction clients, and Community Residential Support Services for Ministry of Health funded Disability Support Services clients.

[6] There may be Regional or District variation, as previously agreed in writing with the Ministry of Health.

[7] Where the person is a minor the usual residence is the usual residence of that person's parent(s) or guardian(s). Children who board at another residence to attend primary or secondary school and return to the home of their parent(s) or guardian(s) for the holidays 'usually reside' at the address of their parent(s) or guardian(s). Post-secondary students 'usually reside' at the address where they live while studying.

- the necessary consumables and equipment before they travel, and / or meeting the cost of services and supplies provided by the destination service, and
- a contact name, address and telephone number in the District serving the intended destination.

7.2 Exit Criteria

Following formal assessment by the Continence Advisor, the Service User will be discharged from the Service when the assessment shows that:

- the planned intervention including continence advice, education, and retraining has been completed, and / or
- they require referral to another health professional for treatment for the cause of the continence problem.
- they cease to meet the Entry Criteria (Sections 7.1 and 7.1.1 above).

On discharge the Service provider will:

- refer the Service User to other services as required
- plan discharge in consultation with the Service User, family and agencies as appropriate and / or arrange for a transfer to another service provider eg. ARRC provider or other funder agreement
- make the written discharge report available to the Service User, and the their GP, and the referrer.

7.3 Response Time

The response time for each referral will be based on the level of risk of the Service User,

which will be assessed from the information given with the referral.

Indicative response times: indicative times from receipt of referral to first contact with the Service User are given in the table below:

Referral Management Process:

Urgency for Initiation of Service Provision According to risk level assessed from referral	**Receipt / Acknowledgement of the Referral to the Service User**	**The Service response to assessed risk for provision of the Service**
Low Risk	within 10 working days of receipt of referral	within 8 weeks of receipt of referral according to assessed need
Medium Risk	within 10 working days of receipt of referral	within 2 weeks of receipt of referral
High Risk	within 8 - 24 hours of receipt of referral	within 24 hours of receipt of referral

8. Service Components

8.1 Processes

Refer to Tier One Community Health, Transitional and Support Services specification for Sections on Service Processes, Pacific Health services, Health for Other Ethnic Groups and Settings.

Service Component	Description
Referral management	Prioritisation and triage for access to the Service will be operated by appropriate registered health professionals within the time frames in this service specification. The referral is returned to the referrer where inadequate information is supplied. If a referral with inadequate information appears to be for a person with a Medium / High risk issue then contact the referrer immediately and ask for more information and return the referral to them for completion. In cases of a Low Risk issue the person will need to be managed by the referrer until the Service User can be seen by the Continence Advisor.
Assessment of: • physical and psychological effects of incontinence • cause of incontinence • emerging complications and the need for medical intervention • ability to self-manage • social circumstances which may impact on the Service User's continence or ability to self-manage.	The Service provider will: • have obtained the results of a microbiological assessment of a mid-stream urine sample (if indicated) • have obtained information on the Service User's medical history including any prior investigation and/or surgical interventions, and the duration of the problem • conduct a thorough assessment in the environment most appropriate to the individual Service User, using clinical assessment tools[8] including, where appropriate, a Per Rectal or Per Vaginal examination to establish the Service User's health status, their risk of deterioration, and level of need • ascertain the clinical viability and appropriateness of using treatment and / or Continence Consumables to manage the Service User's health need, and explore the range of treatment options • refer the Service User to other services as their clinical need requires, notifying the referring health professional and / or other support services as appropriate • conduct ongoing assessment of each Service User's health status to monitor the effectiveness, acceptability, and appropriateness of continuing the provision of continence services and / or Continence Consumables • ensure that the Service User and family / caregiver understand the assessment process

[8] A range of Continence Assessment tools are available on the NSFL website

Service Component	Description
	• take account of the Service User's cultural requirements and include their family and whanau, advocacy and support services as required by the Service User • have a process for resolution of disputes re the level of service delivery.
Planning and Provision • Teaching programmes about pelvic floor exercises, bladder / bowel retraining etc. • Counselling to assist the person make any necessary lifestyle adaptation. • Treatments related to the care of skin integrity. • Treatments related to dietary and fluid management. • Continence Consumable selection and trialling where appropriate.	The Service provider will in conjunction with the Service User: • plan the treatment programme required to optimise the Service User's health status and self-management • develop agreed outcomes and anticipated timelines for the documented treatment plan • provide services that will restore or maintain health status including, as appropriate, input from any or all of the multi-disciplinary team and any other relevant external sources. This may include teaching adaptive or compensatory skills to the Service User where appropriate, or their caregiver or family / whanau • ensure that the services provided under the treatment plan, and the manner in which they will be delivered are understood by the Service User, and where appropriate, by their family, whanau, advocacy and support services • where appropriate, adjust the treatment programme according to the Service User's response and the need to achieve clinical benefit.
Continence Information, Education and Advice	Continence Information, Education and Advice is provided by Continence Advisors, who will, following assessment of the Service User: • utilise a conservative management approach (bladder retraining, pelvic floor muscle training, lifestyle interventions) First line treatment may take 3-4 months to see improvement • provide onward referral where appropriate, if there is no improvement. The Service will provide: • health / wellness education, eg, adaptation or prevention, goal development a holistic assessment and management to help improve the Service User's continence problem • training on the use and application of Continence Consumables to maximise benefit. The Service will recognise the culturally sensitive issues relating to undertaking education activities.
Evaluation, monitoring and reassessment	The Service provider will re-assess the Service User at agreed intervals after the initial assessment, based on their documented plan of care. If conservative management has failed or is found to not be appropriate then Continence Consumables maybe prescribed as an option. The provision of Continence Consumables, in most cases, is not first line treatment. Following the post assessment review the Service User may :

Service Component	Description
	• be discharged from the Service, or • be prescribed Continence Consumables according to their assessed needs, or • continue to be monitored without Continence Consumables being prescribed. Where a Service User remains in the Service, monitoring will continue to: • provide professional supervision / oversight of those Service Users who are being managed by their family or caregivers • ensure clinical benefit continues to be derived for the Service User from the treatment programme and / or supply of Continence Consumables • ensure suitability and utilisation of equipment and consumables, develop a maintenance plan including programme goals, frequency of contact and reassessment criteria.
Provision of Continence Consumables	The Service provider will facilitate access to an identified and / or prescribed amount of Continence Consumables as described in Appendix 2 according to the Service User's assessed need. The Service will discharge the Service User from the supply of Continence Consumables when, following formal assessment of the need for the prescribed Continence Consumables, they no longer meet the access criteria, or are not receiving clinical benefit from the Service as defined in the risk assessment criteria in Appendix 1 The assessment for the need for Continence Consumables will be completed annually. NOTE: Unless a specific exemption is sought through the Crown Funding Agreement or District Annual Plan, no co-payments will be sought from Service users for consumables. Service Users requiring additional supplies over and above what is prescribed will need to pay for these additional supplies.

8.2 Key Inputs

An appropriately trained Continence Advisor (see footnote 3) who has skills in the assessment and management of Service Users with urinary and / or bowel incontinence and cultural advice.

The Service will supply or facilitate access to identified / prescribed Continence Consumables described in Appendix Two of this document, or as determined by the Service User's documented care plan.

9. Service Linkages

The Service will develop and implement protocols for relationships with each of these services / agencies below, to facilitate open communication, continuity of care, smooth referral, follow-up and discharge processes:

- Age Related Residential Care services
- Assessment Treatment and Rehabilitation services
- community and social services, and consumer and carer support / advocacy groups and services, including Māori and Pacific Peoples' services
- Mental Health and Addiction Service providers
- consumer advocacy services
- emergency medical services
- interpreter services
- key worker / care coordinator
- Ministry of Health funded Disability Support Services including Child Development Services
- Ministry of Social Development, Work and Income services for Service Users needing financial assistance for additional continence products
- medical, surgical and maternity services
- palliative care community services
- primary health care services
- residential support services for people with disabilities, chronic health conditions and people with mental health and addiction problems
- schools / colleges
- specialist services for children and young people
- support needs assessment and co-ordination service.

10. Exclusions

Funding for this Service will not duplicate services already funded by the Districts[9] or where the responsibility for funding lies with the Accident Compensation Corporation (ACC).

People with primary nocturnal enuresis who meet the eligibility criteria to access this Service and who are otherwise well, do not meet the criteria for the supply of Continence Consumables.

Continence consumables – where the patient is likely to have a short-term (eg, less than 6 months) need for these supplies arising from their terminal illness, they will be provided by the Palliative Care Community Service[10].

[9]Such as services for people under 65 years old with Chronic Health Conditions in Community Residential Homes.

[10] Tier two Specialist Palliative Care Services service specification

11. Quality Requirements

11.1 General

For every Service User there will be evidence that the initial assessment follows a planned process and that the process, expected outcome and progress toward achievement of outcome are documented. Dates are set and documented for reviewing their long term care plans.

The quality improvement programme [11] must identify requirements of individual Service User care plans and measure response times to referrals, and waiting times for service provision.

11.2 Acceptability

For every Service User, goals will be developed collaboratively with the Service User and their family / whānau / carers according to the Service User's wish and / or condition.

Every Service User will be provided with meaningful continence information on his or her treatment programme.

Service User and carer satisfaction surveys will be undertaken to assess:

- the Service User's satisfaction with their level of involvement in the treatment
- the Service User's and / or carer's satisfaction with the level of information they are given on their treatment programme.
- how well the Service User's cultural needs were recognised and met.

1.1.1 [11] Reviewing the Need for and Current Organisation of Continence Services. A template for New Zealand District Health Boards ,Torfrida Wainwright, For the New Zealand Continence Association. September 2006, Copies available at torfrida@snap.net.nz.

12. Purchase Units

Purchase Units (PU) codes are defined in Health New Zealand's Nationwide Service Framework Purchase Unit Data Dictionary. The following PU code applies to this Service.

PU Code	PU Description	PU Definition	National Collections or Payment Systems
DOM104	Community Services - continence services	A regular provision of continence supplies and related disposable items to Service Users living in the community, as clinically indicated by a Continence Advisor Includes incontinence assessment, and initial education or advice to Service Users and their families or carers Excludes ongoing nursing visits.	National Non-admitted Patient Collection (NNPAC) or Contract Management System (as per contract)

Unit of Measure	Unit of Measure Definition
Client	Number of clients managed by the service in the reporting period i.e. caseload at the beginning of the period plus all new cases in the period.

13. Reporting Requirements

Where this Service is provided by a District the reporting requirement is to NNPAC. The NNPAC file specification and reporting requirements are on HNZ's website.

Where the Service is provided by a non - District service provider, all information / data requested in the reporting requirements of the service specification will be sent to the Funder to upload into the Funder's data warehouse.

Additional Information for use in contracting with non-District organisations

Details of the information and frequency of reporting to the Funder via the Sector Services Contract Management System are as specified by the Funder.

This information below is to be collected for all Service Users by the Services provider for monitoring service provision purposes and to provide a consistent information set for national benchmarking. This information will be made available electronically to the Funder and / or Ministry of Health on request.

- Patient Name
- Patient NHI

- Patient Date of Birth
- Patient Gender
- Patient Ethnicity* (collected and reported at level 2 according to the Ethnicity Data Protocols for the Health and Disability Sector and the supplementary notes and revised code set appendices.[12])
- Referring Practitioner Name
- Date of referral to the Service
- Reason for Referral (Accident /Non Accident)
- Date of assessment
- Date of the Service commencement
- Date of discharge
- Service provided (A different data entry will be completed for every service a Service User receives)
- Service User complexity (as this is defined and negotiated)
- Number of contacts between the service and the Service User
- Date of reassessments.

Unless otherwise specified in the agreement, the reporting will be sent to:

The Performance Reporting Team, Sector Operations via email to:
performance_reporting@moh.govt.nz

14. Glossary

Not required

15. Appendices

[12] http://www.health.govt.nz/publications/ethnicity-data-protocols-health-and-disability-sector.

15.1 Appendix 1: Risk Assessment Framework

High Risk:

Failure to provide the service may result in the person:

Being in unnecessary pain

Imminently being admitted as an in-patient for symptom control

Experiencing irreversible deterioration of their health status requiring their long-term in-patient medical/surgical management

No longer being able to stay in their own residence

Medium Risk:

Failure to provide the service may result in the person:

Being unable to self-manage with resulting dependency on alternative options which may compromise their health status

Needing to be referred to a specialist for consultation and / or management of a health condition

Continuing with compromised health status which is not life-threatening but if left permanently un-managed would lead to more extensive and/or additional problems

Being unable to self-manage thus placing significant pressure on the family, caregiver which may cause their health status to be compromised

Being admitted to short-term care to provide respite for the caregiver

Low Risk:

Failure to provide the service may result in the person:

Living with a limited degree of compromised health status which is not in any way life threatening but intervention would enable them to return to optimal health status and/or function safely and independently

This framework is presented as a continuum of risk in terms of the person's health. There will, therefore be people who will not be eligible for service as a result of assessment, or reassessment of their risk. This would relate to people, who on assessment or reassessment, present with needs that are:

Beyond those suggested in the Framework as 'High Risk'. They have excessive and complex needs requiring:

- management in an alternative environment eg. palliative care
- continuous intervention by a clinical team which includes specialist medical involvement eg, inpatient facility

Below those suggested in the framework as 'Medium Risk'. They are functionally independent and have a level of compromised health status that does not require specialist services. The services to meet their level of need could appropriately be provided by the GP and/or practice nurse

Below those suggested in the Framework as 'Low Risk'. They are people for whom the sole purpose of the service would be to provide comfort, convenience or emotional security for them and/or family but for whom no clinical benefit would be gained by the provision of the service.

15.2 Appendix 2: Guidelines for the Supply of Consumables

All items are supplied at the discretion of the Specialist Continence Nurse, as clinically appropriate and are to be included in the consumable prescription.

Provision of consumables will usually be prescribed as per the guidelines given in the table below and where they meet the DHB's own criteria for supply.

These guidelines are a tool to assist decision making about the appropriate prescription of product based on the Service User's assessed need.

Note: There may be occasions when it is appropriate to prescribe more product than is indicated in the guidelines, or when it may be justifiable to prescribe products not included in these guidelines that are listed in the relevant National Product Supply Agreement.

Product	Type	Range
Pads	350 ml capacity and up (adults)	2 - 4 per day
Uridomes		Up to 60 per month
Leg Bags Night Bags	Standard Standard	2 to 4 per month 2 to 4 per month
Net Pants		2 per 3 months
All-in-one briefs (nappies)		Up to 4 per day
Continence pants	Training pants[13]	Up to 4 per day
Intermittent Catheters		Up to 90 per month
Indwelling Urethral Catheter		1 to 6 every 3 months
Suprapubic Catheter		1 to 6 every 3 months
Washable bed pads		up to 3 per year, if not using other disposable products
Gloves	Latex	100 – 200 every 3 months
Catheter fixation devices	Thigh Straps or Leg Straps	1 every 3 months
Skin Bond		1 -2 per month
Urihesive Strips		30 - 35 per month
Catheter Valves		2 to 4 per month as per manufacturer's instructions.

[13] **Guidance criteria for access to continence / training pants:**
The Service User must be able to mobilise, has trialled other products unsuccessfully, and:

- Is a child over the age of 4 years who has an incontinence problem which is inconsistent with normal development
- has a diagnosis of dementia, poor dexterity high falls risk,
- has access at the discretion of the Continence Advisor.