***ENURESIS***

***POLICY***

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1. **Introduction**

 High Quality Care for All provides a vision for the future development of NHS Services which reflect the needs of local communities. (2008)

 Nocturnal enuresis or diurnal enuresis is a common and distressing condition that can have a

 deep impact on a child’s confidence and self esteem. It can also be stressful for parents and

 those caring for children and young people.

1. **Policy Statement**

 This Policy is aimed at providing a cohesive plan to deliver a high quality Enuresis service.

 This Policy sets out the boundaries within which enuresis services are delivered by CHCP

staff. It clarifies the processes, mechanisms, roles and responsibilities of all staff involved in the delivery of service to support children, young people and their families who are experiencing diurnal or nocturnal urinary continence problems primary or secondary.

 The aim of this policy is to achieve maximum efficiency and to provide a responsive enuresis service, which meets locally agreed protocols and NICE guidance.

This policy applies to all City Healthcare employees.

This policy is to be communicated to all City Healthcare Partnership staff who come into contact with children and young people including those who provide services for children 5yrs and over.

**3.0 Scope of the Policy**

This policy applies to all Healthcare professionals employed by City Health Care Partnership (CHCP), Children’s Directorate, including all agency staff. It is the responsibility of all staff to work together with partner agencies to identify barriers to service delivery, in order to promote an effective and efficient service.

This Policy should be read and implemented in conjunction with:

* Hull CHCP - Infection Control Policy
* Hull CHCP -Supervision Policy
* Hull CHCP – Consent to examination or treatment
* CHCP – Healthy Child Programme Birth - 19yrs
* CHCP – Operational Framework for the Healthy Child Team

**4.0 Equality and Diversity Statement**

* The organisation aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

**5.0 Definitions**

* A practitioner is defined as a person who is either, a registered doctor, dentist or nurse who is registered with the Nursing and Midwifery Council as an Nurse Independent / Supplementary Prescriber.
* Diurnal enuresis is defined as the involuntary passage of urine during the day in a child beyond the age of 5 years which occurs more than once a week where there are no known organic causes.
* Primary Nocturnal Enuresis is defined as the involuntary passage of urine at night in a child who has not been dry for a period of 6months.
* Secondary Nocturnal enuresis is defined as the involuntary passage of urine at night in a child who has previously achieved a significant period of dryness prior to the onset of the current episode of wetting.

**6.0 Process**

**Criteria for referral**

A referral to the Enuresis service may be necessary when a child is displaying significant symptoms of nocturnal or diurnal urinary symptoms.

Criteria for referral:

1. The child is 5yrs or over.
2. The child has a history of never being dry.
3. The child has daytime wetting symptoms.
4. The child wets the bed 4 or more times per week on a regular basis.
5. The child has previously been dry at night but is now wetting more than 4 times per week.

All referrals or request for an alarm from General Practitioner, paediatrician or parent will be directed to one of the three locality teams in the first instance.

All referrals to the Enuresis service will come via the School Health Teams who will make initial contact with the family giving them information on the following in conjunction with Enuresis checklist for School Health Teams.

* Constipation.
* Recommended fluid intake.
* Good toileting/ bedtime routines.
* Ways to increase fluid intake.
* Handy hints for children with daytime or night time symptoms.
* The parent will be advised to contact the School Health teams if the symptoms do not improve or resolve within eight weeks.
* When a parent contacts the school health team requesting further support the school health team will make a referral to the Enuresis Service. A referral to School Nursing Enuretic service template will be completed on SystmOne (S1) and an electronic referral sent. The template will include details of relevant history, service level and work carried out to date by the School Health Team. The referral will be sent to the Single Point of Access Team to be triaged by the continence nurse or a senior nurse.
* A full assessment will be carried out by a qualified RGN using the Three Systems Model (Butler 2000) and in line with NICE Guidelines 2010.
* If the referral is accepted, the SPOA will generate and send a letter to the parent advising that they should contact the SPOA to request an appointment. The client’s name will be placed in the continence pending folder on S1 by SPOA and will remain in the pending folder for 3 weeks until the parent contacts the service for an appointment.
* If the parent does not contact the service within 3 weeks the referral will be ended with the continence Service. A letter will be sent to the referrer informing them of the discharge by the SPOA.
* If the client contacts the School health team within 12 months requesting further support the school health team can make a referral to the continence service without giving further advice and waiting eight weeks.
* If the parent contacts the SPOA, a clinic appointment will be made on S1 and a clinic appointment letter sent to the client by the SPOA. The client will choose the venue which is most suitable for them. The name will then be placed in the active caseload folder by the person making the appointment.
* When a client attends for the first appointment a full assessment will be carried out using the S1 template. The first template will be the continence assessment template which will determine which Enuresis care pathway template the clients care will follow.
* Review appointments will be given on the day of the clinic until symptoms are improved or the child is dry for 14 consecutive nights. The relevant care plan will be used for follow up appointments. Follow up appointments may be facilitated by Health & Development Practitioners.
* When a client is assessed as requiring medication to treat their condition the continence nurse will write to the client’s GP highlighting the condition that has been identified through assessment. The parent or carer and the client will be advised to make an appointment with the GP to discuss the treatment options available. When a client is taking medication they will be monitored on a regular basis by the continence nurse. If the client does not wish to be monitored in this way they may do this through their own GP.
* When a client fails to attend a clinic appointment they will be discharged and a letter sent. If the client is on medication then a letter informing them of the need for regular monitoring will be sent to the referrer.
* When a client contacts the School Health team within 12 months requesting Enuresis support they can be referred immediately the continence service. When a client contacts the School health team after a 12 month period has elapsed the team will contact the client and offer support in the first instance.

Referral received into incoming folder initial letter sent to parent

Initial letter to parent sent

REFERRAL PATHWAY ENURESIS

Name placed in pending folder on systm 1

Concern identified by

* Parent on consent
* School staff
* GP letter
* Health Visitor

Parent fails to contact within 4 weeks

Parents contact within 4 weeks

Client discharged

Task sent to School Nurse Team

Appointment for clinic sent and put on active caseload

School Nurse Team to contact parent and offer advice: fluid intake, bedtime routine, constipation and send supporting material parent to contact team after 8 weeks.

Client seen in clinic. Further appointment given

Failed to Attend.

Discharge and inform referrer

Letter to GP sent

IMPROVEMENT contact details given to parent if they should require service.

Review clinic appointment

NO IMPROVEMENT School Nurse Team to send referral to SPOA

Symptoms improved discharged

Evaluation letter sent to parent

**7.0 MONITORING**

 **Implementation and compliance:**

 All staff must adhere to this policy. Incidents reported through the Datix incident reporting system and reviewed quarterly at the integrated governance forum.

 Staff attending training is monitored through the use of Electronic Staff Records and Education database.

 Authors are required to review existing policy and undertake uptake every 3 years or earlier if deemed necessary by changes to NICE Guidance.

 Authors are responsible for bringing the contents of this document to their own Clinical Governance Forum and Business Unit meetings as appropriate and to ensure appropriate delegation of responsibility occurs to ensure dissemination and implementation of the policy.

 This policy will undergo audit within 6 months of approval and there after every year, to monitor compliance and effectiveness.

 APPENDIX 1

ALARM AGREEMENT

NAME-------------------------------------DOB------------------------------------------------------

ADDRESS---------------------------------------------------------------------------------------

SCHOOL-----------------------------------------------------------------------------------------------

This alarm is loaned to you for a limited period and it is important that you return it when is no longer required as the alarms are expensive and we have a limited supply. Once returned we can issue it to another client waiting for an alarm.

Thank you for your co-operation.

Signed---------------------------------------

Date alarm taken--------------------------------------------------

Date alarm returned----------------------------------------------

You may return the alarm to the clinic which you attend or make contact on this number 344041 to arrange return of your alarm.

APPENDIX 2

Dear ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Our records show that a bedwetting alarm is on loan to you.

Some time has elapsed since you and your child attended our clinic.

There is a very long waiting list of families wanting to use this expensive piece of equipment. Please return the alarm to the clinic as soon as possible or to your child’s school if it is more convenient.

Should you still be experiencing difficulties and would like further help and advice, please do not hesitate to contact us.

Yours sincerely

Lead Nurse for Enuresis

APPENDIX 3

**ALARM MONITORING PROGRESS CHART**

Name ……………………………………………………………………………………………………………

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date** | **Self Waking** | **Woke to alarm Y/N** | **Size of wet patch****VS/S/M/L** | **Time of triggering** | **Dry****✓** |
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**Taking DesmoMelt - Patient Information** APPENDIX 4

**About primary nocturnal enuresis**

Primary Nocturnal Enuresis (PNE) is the name given to the condition in which your child has always wet the bed. It can happen when your child’s natural control of night time urine production does not develop quickly enough.

**What is DesmoMelt?**

DesmoMelt is a medicine prescribed for children with PNE.

The body controls urine production with a substance called vasopressin, which acts on the kidneys to reduce the production of urine so that it takes longer to fill the bladder. Children with PNE may not yet have developed the ability to make enough vasopressin at night.

The active ingredient in DesmoMelt is called desmopressin, and it is very similar to natural vasopressin. So, by prescribing DesmoMelt your doctor is helping to normalise your child’s night time urine production

**Why Treat now?**

Bed wetting can be a traumatic and humiliating experience for a child and may lead to lowered self-esteem. As children get older and interact more with other children and adults they can become very distressed by continued wet nights. It can also lead to frustration and stress for parents too.

By treating quickly without undue delay, you and your doctor can help restore normality to a child’s life and future development.

**Taking DesmoMelt**

DesmoMelt is taken by placing it under the tongue. Your doctor will tell you how long your child should continue taking DesmoMelt.

Do not adjust the dose yourself. Talk to your doctor if you think the effect is too weak or too strong.

Fluid intake must be limited to a minimum from one hour before until 8 hours after taking DesmoMelt, because it works by holding back water in the body overnight. Although it is very rare, too much fluid in the body can lead to problems that may need medical attention. If you experience an unusually bad or prolonged headache contact your doctor, nurse or pharmacist.

**What can I expect?**

Some children experience dry nights very soon after starting DesmoMelt. If there is no improvement the doctor may adjust the dose. Treatment is normally reviewed every three months. Those who do well with DesmoMelt will normally continue for some time before their natural ability to control night time urine production ‘catches up’.

Successful treatment may improve the quality of the child’s life.

APPENDIX 5

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APPENDIX 6

**HANDY HINTS FOR CHILDREN WITH DAYTIME/NIGHTIME WETTING**

15% OF ALL CHILDREN HAVE THIS PROBLEM SO DON’T WORRY TOO MUCH.TRY TO FOLLOW THE HINTS BELOW.

1. Remember that bedwetting is not the Childs fault.
2. Do not restrict fluids; young children should be aiming to drink 7 drinks of 200 mls per day. Fluids should be evenly distributed throughout the day between waking and 6.30pm.
3. Do ensure the child goes to the toilet soon after the last drink and again before bed. (To ensure

that the bladder is completely empty).

1. Give praise and encouragement for effort and agreed goals. (Finishing a full drink)Ensure that your child has a healthy diet to prevent constipation. (Ask for further advice if you feel your child is constipated).
2. Try not to use pull-ups or nappies. Use a mattress protector or a re-usable bed sheet to absorb the urine (Ask for more information if required).
3. Ensure night lights are on and a passage to the toilet is well lit. A potty in the bedroom could be used.
4. Do not discuss wetting in front of other people.
5. Try not to lift the child but if you do make sure the child is fully awake.
6. If the child wets, change the bedding and clothing .Encourage the child to help to put the bedding in the wash basket .Ensure the skin is washed before applying creams .Do not allow the child to get into another persons bed.
7. Avoid tea coffee chocolate or any caffeine based drinks. Avoid fizzy carbonated drinks and blackcurrant juice.
8. Do not criticise or reprimand the child for wetting.
9. Wash the sheets in cold water and or use napisan this helps to reduce the smell.

APPENDIX 7

**OVERACTIVE BLADDER INFORMATION SHEET**

Your Child may have been told that they are showing signs of an overactive bladder.

The main symptoms are having to hurry to pass urine, passing reduced amounts (below the average bladder capacity) urine leakage may also be experienced day or night and you may notice that your child goes to the toilet frequently during the day.

The bladder may be unhappy to hold sufficient amounts of urine and may start to become twitchy (irritable) when only a small amount of urine is sitting in the bladder. This gives a strong feeling of wanting to go to the toilet which does not fade until the bladder is emptied. The irritability of the bladder may also cause some urine loss or dribbling.

Overactive bladder symptoms can be worsened by constipation. Therefore you nurse will have given you information on how to treat or improve this.

Over active bladder symptoms can also be made worse by a low fluid intake or fizzy drinks or caffeine based drinks. An expected fluid intake for a 5 year old would be approximately 1400ml 5-7drinks,10yrs approximately 2000mls 7-10 drinks,15yrs 2500mls 10-12 drinks per day.

It is important for your child to completely empty their bladder when using the toilet. Some tips below may help;

®Make sure you child sits on the toilet correctly (feet supported)

®Sit on the whole seat (don’t perch)

®Bend slightly forward to relax the tummy muscles.

®Listen to the wee, is it coming out in one stream don’t let is stop and start.

The aim of treating the overactive bladder is to try and slowly increase the bladder capacity which can help to reduce the irritability of the bladder.

Your nurse will give you advice to follow about trying to increase the time between visits to the toilet and you may like to keep a record or diary to see if you can notice any improvement in the frequency your child needs the toilet. It may take some time before you notice a significant difference

Your nurse may ask you to measure your childs urine output to see how much the bladder is able to hold.

Average bladder capacity is worked out by age x 30 +30. (7yrs x30=210mls +30 = 240mls).

APPENDIX 8

**INFORMATION LEAFLET FOR CHILDREN TAKING OXYBUTININ MEDICATION**

Your child has been prescribed Oxybutinin Hydrochloride. This medication is available in syrup and tablet form.

The medication works by helping the bladder muscle relax and helps to reduce some of the erratic bladder contractions your child has been experiencing.

This should help to increase the amount of urine your child is able to hold in their bladder and help them to stay dry. If your child has been experiencing the need to rush to toilet then this should also improve.

The medication should be given as prescribed and the child should also follow any other advice which has been given by the school nurse, for example increase their daily fluid intake, reduce fizzy drinks and perform a bladder training regime.

The medication will be more effective if combined with the above advice. If the medication is tolerated it is usually given for at least **3 months** – therefore once the first prescription has run out, please re-order it from your GP.

Side effects from this medicine are not common. However there are several minor side effects that you may notice;

Dry mouth

Dry skin

Facial flushing

Constipation

If your child does develop any of these symptoms do not stop giving the medication but do let your school nurse/GP know at your next appointment or sooner if you are concerned.

It is very important that constipation is avoided or treated quickly as this can make your child’s bladder symptoms worse.

There are other side effects which may occur in a small number of children.

Blurred vision Dizziness

Skin rash Sleep disturbance

Mood swings Headache

Drowsiness or irritability

If your child develops any of these symptoms, contact your school nurse/GP for further advice.

**Please make sure your child brushes their teeth regularly.** This is important when taking Oxybutinin as the mouth may become dry due to the reduction in saliva production. Saliva is necessary to protect teeth from decay.

These are only guidelines but please remember that many children do not suffer from any side effects.

APPENDIX 9

**Practice waking sheet**

This exercise is designed to improve the chances of waking up when the bladder is ready to empty.

It is important to know that it is possible to wake up if we need to. However we need to be PREPARED wake up. We tend to wake up when we recognise a signal as important. Thus we might wake up if we feel sick, have a bad dream or hear thunder. We sleep through signals such as traffic noise if we do not think it is important.

The important thing is to prepare ourselves to wake up when we need the toilet. Try before going to sleep to do the following exercise:

* **Lie on your bed with your eyes shut.**

**🞏 Feel your bladder filling and reaching bursting point.**

**🞏 Tell yourself that when you feel your bladder full you will wake up.**

**🞏 Open your eyes and go to the toilet.**

**🞏 Attempt to urinate in the toilet.**

**🞏 Practice 5 times.**

**🞏 On the final time practice the visualisation you have made up.**

APPENDIX 10

RECOMMENDED DAILY FLUID INTAKE

Fluids should be evenly distributed throughout the day and the child should be encouraged to finish the

full drink. Fizzy/carbonated and caffeine based drinks should be avoided.

|  |  |
| --- | --- |
| 4-8 years MALE AND FEMALE  | 1000-1400mls 5-7 DRINKS OF 200 MLS |
|  9-13years MALE FEMALE | 1400-2300MLS 7-12DRINKS OF 200 MLS1200-2100MLS 6-11 DRINKS OF 200 MLS |
| 14-18years MALE FEMALE | 2100-3200mls 11-17 DRINKS OF 200MLS1400-2500MLS 7-13 DRINKS OF 200MLS |

**NICE Gudelines** Nocturnal enuresis: the management of bedwetting in children and young people. NICE guidelines [CG111] Published date: October 2010

APPENDIX 11

SUGGESTED WAYS TO IMPROVE FLUID INTAKE

1. When the child is at home all day fill up an empty lemonade bottle

with a litre of juice or water and encourages them to finish the whole bottle between getting up and the last drink.

1. Dedicate a special cup which will hold 200ml and always

encourage them to finish the drink give lots of praise for doing so.

1. Always provide a drinks bottle for the child to have in school

which they can drink and fill up throughout the day.

1. Speak with the class teacher and ask them to allow and

encourage the child to drink.

1. Provide a separate bottle of drink for the child to drink on the way to school when walking or riding in the car.
2. Fill in a drinks chart to visually encourage the child.
3. Offer reward for achieving agreed daily intake.
4. When the child is at another person’s home ask them to follow on

 with your drinks routine.