Introducing a pelvic floor telephone assessment service

Carlene Igbedioh, Andrew B Williams, Alexis Schizas

This article looks at a telephone triage assessment clinic that was set up to improve the bowel, bladder and pelvic floor service in the authors’ locality. A pelvic floor triage questionnaire was developed to identify patients’ faecal, urinary and prolapse symptoms then, between April and December 2013, patients were referred to the colorectal pelvic floor clinic via telephone triage assessment. Investigations could also be requested directly from the telephone triage assessment clinic. The need for any investigations and patient responses to the telephone triage assessment clinic questionnaires were reviewed in the pelvic floor multidisciplinary meeting. Previously, the wait for a new pelvic floor appointment was four months and this has been reduced to two weeks (or five weeks for a new consultant appointment). The telephone triage assessment clinic has led to a reduction in waiting times, an improvement in patient experience and more efficient referral. It is also more cost effective as it can replace a new consultant appointment.

KEYWORDS: Continence ■ Telephone triage assessment ■ Bowel ■ Bladder

Bowel and bladder problems are a common cause of functional and quality of life issues for people in the community and it is imperative that nurses have the knowledge and skills in order to deal with continence issues should they arise.

Bowel symptoms are commonly encountered in community settings, with prevalence increasing with age — for instance, one-third of women and one-quarter of men aged over the age of 65 report recurrent constipation (Campbell et al, 1993). However; colonic transit can also be affected by comorbidity (e.g. in people who are immobilised through illness or medication) rather than ageing alone. Other risk factors include low calorie diets, enteric feeding and dehydration (Bharucha et al, 2013). Diseases such as Parkinson’s, diabetes, stroke, renal dialysis, depression and dementia can also affect the functioning of the bowel.

Urinary incontinence is also a more common problem than is often realised. In the UK it is estimated that at any one time at least 5% of the total population experience urinary incontinence, while the NHS estimates that between three and six million people in the UK have some degree of urinary incontinence (Royal College of Physicians, 2005).

In 2010, the International Continence Society restated the definition of overactive bladder syndrome as a condition characterised by (Marinkovic et al, 2012):

- Urinary urgency, usually accompanied by frequency and nocturia, with or without urgency incontinence, in the absence of urinary tract infection or other obvious pathology.

Community nurses are ideally placed to advise other clinicians about patients with bladder and bowel symptoms, including the most

THE SCIENCE — COMMON BOWEL SYMPTOMS

Symptoms of bowel dysfunction are varied, but common problems include:

- Difficulty having bowel movements or less than three bowel movements per week may indicate constipation, as does straining on the toilet or not feeling ‘empty’.
- Passing ‘watery’ or very loose stools over three times a day.
- Abdominal pain (located in the lower left stomach) and changes in bowel habits, such as constipation or diarrhoea as well as mild fever, nausea and vomiting are symptoms of diverticular disease.
- Diarrhoea, weight loss and abdominal pain are symptoms of Crohn’s disease.
- Bloody or mucus-filled diarrhoea as well as a constant urge go to the toilet are symptoms of ulcerative colitis.
- Leaking faeces without being aware of it is a sign of faecal incontinence.

Source: Bladder and Bowel Foundation: www.bladderandbowelfoundation.org

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Recently, there has been an increase in demand for continence services, as incontinence becomes less of a taboo, and patients who have become used to managing their own symptoms realise that they can access treatment. In the authors’ experience, GPs are also becoming more aware of pelvic floor services and are now referring patients for treatment.

To implement an integrated plan, modern continence services need to be continually updated. However, an efficient continence service depends upon organisational reform rather than large-scale financial investment (Abram 2002a; 2002b).

The importance of promoting best practice through an integrated continence service was established by the Department of Health (DH, 2000), which stated that an integrated continence service should provide expert advice and be available to people whose condition does not respond to initial treatment, as well as including designated medical and surgical specialists to provide a clear pathway of care.

<table>
<thead>
<tr>
<th>Table 1: Referral/vetting criteria for telephone triage system</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Referral sources</strong></td>
</tr>
<tr>
<td>Colorectal clinics</td>
</tr>
<tr>
<td>Consultant’s clinic (all by letter)</td>
</tr>
<tr>
<td>Physiotherapist</td>
</tr>
<tr>
<td>Urogynaecology nurse</td>
</tr>
<tr>
<td>Consultant nurse</td>
</tr>
<tr>
<td>Medical, surgical, elderly care out-patient clinics and wards</td>
</tr>
<tr>
<td><strong>External</strong></td>
</tr>
<tr>
<td>GPs’ letter</td>
</tr>
<tr>
<td>Other hospital/specialist centre</td>
</tr>
<tr>
<td><strong>Referral guidelines — each referral is vetted against the following criteria:</strong></td>
</tr>
<tr>
<td><strong>Inclusion criteria</strong></td>
</tr>
<tr>
<td>Patients with the following symptoms:</td>
</tr>
<tr>
<td>Constipation</td>
</tr>
<tr>
<td>Evacuation difficulties/outlet obstruction on defecation</td>
</tr>
<tr>
<td>Bowel leakage/incontinence</td>
</tr>
<tr>
<td><strong>Exclusion criteria</strong></td>
</tr>
<tr>
<td>Red flag symptoms (not pelvic floor), such as rectal bleeding; change in bowel habit; weight loss; vaginal bleeding; haematuria; voiding difficulties</td>
</tr>
<tr>
<td>Inappropriate referrals, poor referral/lack of adequate information on letter</td>
</tr>
<tr>
<td>Specific tertiary referral/second opinion — patient sent straight to pelvic floor clinic</td>
</tr>
<tr>
<td>Language barrier — if interpreter is required, service is not appropriate</td>
</tr>
<tr>
<td>Multiple/significant comorbidity may impede nurse from collecting all of the patients’s history</td>
</tr>
</tbody>
</table>

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**BACKGROUND**

Historically, referrals to the authors’ pelvic floor service were vetted through a consultant clinic. Patients attended hospital for a consultant consultation, after which they might have been sent to the pelvic floor service for a series of tests. Consultations took place in busy clinics and patients were asked a series of intimate and often embarrassing questions in what was often an unfamiliar environment.

After the series of tests, patients might have been referred for conservative treatment in the bowel function clinic (such as biofeedback), or back to the consultant clinic for a discussion about surgery.

Biofeedback uses symptom assessment, bowel and muscle retraining, behavioural therapy, visual education and psychological support to help people regulate their bowel function (Schwartz et al, 1995).

For instance, by using a combination of internal sensors, electrodes placed on the abdomen and a computer screen, biofeedback training can help the patient to coordinate the sphincter muscles and improve his or her ability to sense the presence of faeces in the rectum.

If conservative measures failed, patients were also referred back to the consultant to discuss surgical intervention, which includes transvaginal rectocele repair, ventral mesh rectopexy, anal sphincter repair, the use of bulking agents and neuromodulation.

Due to the number of diagnostic stages in the pathway, the specialist

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**The Science — Common Bladder Symptoms**

Symptoms of bladder dysfunction include:

- A sudden urge to go to urinate or difficulty ‘holding on’ is a symptom of urgency or urge incontinence
- Needing to urinate more than eight times in a single day can be a sign of urinary frequency
- Nocturia is signaled by repeated urination through the night; nocturnal enuresis is wetting the bed at night
- Mixed urinary continence is signaled by a mixture of the above symptoms
- Urination upon laughing, coughing, sneezing or exercise is a symptom stress urinary incontinence (SUI)
- Overflow incontinence is signaled by small leakages of urine that are not noticed by the individual.

Source: Bladder and Bowel Foundation: www.bladderandbowelfoundation.org
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Answer the following questions about this topic, either to test the new knowledge you have gained or to form part of your ongoing practice development portfolio.

1 – What are the common causes of colorectal problems?
2 – Can you name some of the signs of bowel problems?
3 – Do you understand what telephone triage is?
4 – What are the main benefits of phone triage?
5 – Can you explain how integrated referrals might benefit your area?

nature of pelvic floor problems and increasing demand, patients requiring both conservative and surgical treatment were having to wait an increasing amount of time to be seen.

THE NEW MODEL

In response to increasing demands on the service and the need to reduce waiting times, the authors introduced a telephone triage assessment clinic. This involved patients being interviewed in their home so that they could discuss delicate pelvic floor issues in a familiar environment, without having to travel what were sometimes long distances for an assessment.

Under the new system, patients are initially vetted using an assessment protocol (Table 1; Figure 1), before being given a telephone triage appointment. Patients are sent a detailed patient information sheet along with a date and time to wait by their phone.

A healthcare professional with significant expertise in pelvic floor pathology then calls the patient and talks through a continence-specific questionnaire, which has been developed to assess the patient’s symptoms and identify those with combined symptoms as these are not always apparent in an initial referral (this phone call is usually made by a senior nurse but can also be delivered by a specialist physiotherapist or a medical consultant).

The questionnaire poses a range of questions, for example:

- On average how many times do you open your bowels in a 24-hour period?
- Do you have to rush to the toilet when you need to open your bowels?
- Are you able to control accidental loss of formed, watery or loose stool leaking from your back passage?
- Do you have bowel ‘accidents’ when you have no need to open your bowels?
- Is it difficult to hold urine when you get the urge to go?
- Do you leak urine?

This questionnaire has been designed to identify where input from other specialities, particularly...
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urology and/or urogynaecology may be required. At the start of the telephone assessment, patients are asked about specific ‘red flag’ symptoms for colorectal, urological and vaginal pathology, such as rectal bleeding; changes in bowel habit; weight loss; vaginal bleeding; haematuria; and voiding difficulties. If there are any red flag symptoms, the appropriate diagnostic test/s are requested (if they have not already been requested before referral).

Following analysis of the questionnaire, the patient may be referred directly for appropriate conservative management or further investigations if necessary. The telephone interview will also identify those patients who require surgical review before treatment of any incontinence issues. Where it is clear from the original referral letter that a direct clinic appointment is required, this will be made for the patient.

The results of the investigations are discussed in the colorectal multidisciplinary team meeting, then patients are referred for biofeedback or consultant clinic. Those patients with combined symptoms are discussed in the new joint pelvic floor multidisciplinary team meeting with the urology and urogynaecology teams. Following this, the patient is referred for biofeedback or new joint consultant clinic.

The telephone triage assessment clinic runs three times per week and has both morning and afternoon clinics to provide a flexible approach.

AUDIT

The authors performed an audit to assess the suitability of the telephone triage assessment clinic and whether it:

- Adequately streamlined the patient pathway
- Offered an integrated service
- Reduced waiting times
- Offered a better patient experience
- Provided a cost-effective service.

From March to November 2013, all data from the telephone clinic questionnaires was collected and then retrospectively reviewed by the authors.

Results

The telephone triage assessment clinic led to a reduction in waiting times, an improvement in patient experience and efficient referral to appropriate treatment. It also proved more cost effective, as the telephone assessment replaced the old system where the patient would require a new consultant appointment.

Overall, the authors’ findings were:

- In total, 201 patient were reviewed
- Fifty-four percent of patients had combined symptoms
- Seventy-seven percent went on to receive biofeedback
- Twenty-three percent went on to a consultant clinic following review in the multidisciplinary meeting
- Seventeen percent subsequently underwent surgery, including ventral mesh rectopexy and transvaginal rectocele repair
- In 13% of patients, conservative measures failed and they were referred back to the consultant clinic to discuss further options, i.e. surgery
- Three percent of those referred from biofeedback underwent an operation
- Three patients (1%) did not attend their appointment with the telephone triage assessment clinic
- On average, the time taken from telephone triage assessment clinic to biofeedback was seven weeks
- All patients were satisfied with the telephone triage assessment clinic (patients were asked if they were satisfied with the service at the end of the phone call)
- The wait for a new pelvic floor appointment before introduction of the telephone triage assessment clinic was four months — this was reduced to two weeks. There is now a five-week wait for a new consultant appointment.

DISCUSSION

This telephone triage assessment clinic replaced the old system where patients were given a new appointment with a consultant, irrespective of their symptoms. The continence questionnaire that forms part of the telephone assessment allows patients to be directed to the appropriate clinic, thereby reducing the number of unnecessary patient visits to hospital.

As the continence questionnaire also identifies urology and urogynaecological symptoms, multidisciplinary meetings with colorectal, urology and urogynaecology departments were set up and joint colorectal, urology and urogynaecology clinics were established. This further reduced the number of new consultant appointments across a range of specialties and has led to a reduction in waiting and fewer hospital visits.

The integration of referrals has aided integration of the continence service. Patients assessed by the integrated referral service now have access to individual clinics (biofeedback, physiotherapy or surgery), whereas those with combined incontinence symptoms have access to combined (urogynaecology) clinics.
CONCLUSION

The authors of this study set out to devise a new way of arranging referrals in the locality’s busy bowel, bladder and pelvic floor service. In response to increasing demands on the service and the need to reduce waiting times, the authors introduced a telephone triage assessment clinic, which involved patients being interviewed in their home so that they could discuss delicate pelvic floor issues in a familiar environment without having to travel what were sometimes long distances for an assessment.

An audit of the new service showed that patient’s in the authors locality who require an integrated referral service now have a shorter wait for appointments. Also, the number of patient visits to outpatients has been reduced.

REFERENCES


KEY POINTS

- This article looks at a telephone triage assessment clinic that was set up to improve the bowel, bladder and pelvic floor service in the authors’ locality.

- Overall, 201 patients were reviewed by the telephone triage clinic and 54% of these were found to have combined faecal and urinary symptoms.

- One hundred and twenty-seven patients were referred to the biofeedback clinic and 29 to a consultant clinic following review in the multidisciplinary meeting.

- The telephone triage assessment clinic has led to a reduction in waiting times, an improvement in patient experience, and more efficient referral.

- It is also more cost-effective, as it can replace a new consultant appointment.

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