United Kingdom Continence Society: Minimum Standards for Urodynamics, 2018

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8 Appendix

This appendix includes examples of practice and documents required in every UDU. Individual organisations may wish to develop their own versions according to the needs of their patients in general and specific patient groups, in particular, and local factors. The documents listed can be accessed through the UKCS website www.ukcs.uk.net

8.1 Urodynamics antibiotic policies:

8.1.1 Adult UDU Bristol Urological Institute

BUI Antibiotic Policy Notes for High Risk Patients

1. When booking UDS

- Ask patient to see GP, 2 weeks prior to UDS appointment, and have dipstick and/or MSU,
  - If positive, GP to treat UTI and UDS to be booked after ensuring that antibiotic prophylaxis will be arranged by GP.
  - If negative, book after arranging prophylaxis
- Patients with an indwelling catheter should have a CSU sent 2 weeks prior to UDS with the request – For Urological Instrumentation – in the Clinical Details. This need not be treated with antibiotics unless the patient is symptomatic. Please see point 2 below

2. At the UDS appointment

2.2 If has IDC, do not do dipstick (as will always be positive) but send CSU.
- If asymptomatic - proceed if has had prophylaxis, or delay UDS for 2 hours after oral prophylaxis, or give IV prophylaxis (see below).
• If symptomatic (e.g., urine smells and looks foul, or feels unwell and/or temperature raised) do not proceed. Give nitrofurantoin for 5 days and rebook UDS, asking the patient to see GP 2 weeks prior to UDS appointment for dipstick and/or MSU and give prophylaxis for next UDS (see below).

5.1 **Other high risk patients:** do dipstick test, including if on ISC, but not if patient has an IDC.

5.1.5 If negative proceed if has had prophylaxis, or delay UDS for 2 hours after prophylaxis, or give IV prophylaxis no longer than 60 min before UDS (see below).

5.1.6 If positive but asymptomatic, proceed if has had prophylaxis or delay UDS for 2 hours after prophylaxis or give IV prophylaxis (see below).

5.1.7 If positive and symptomatic – do not proceed, send MSU, give nitrofurantoin for 5 days and rebook UDS, ask patient to see GP two weeks prior to UDS appointment for dipstick and/or MSU and give prophylaxis for next UDS (see below).

5.1.8 Make it clear to GP and patient that they need to make sure that the MSU result is known and acted on as appropriate.

**Low Risk**

1. **When booking UDS**
   - Book without prophylaxis.

2. **At the UDS appointment**
   - Dipstick test all patients
   - If nitrite negative – proceed.
   - If nitrite positive and asymptomatic – do not proceed, send MSU, give nitrofurantoin for 5/7, rebook, ask patient to see GP 1 week prior for dip/MSU and give prophylaxis for next time. It is the responsibility of Urodynamic Unit to chase MSU result.
   - If nitrite positive and asymptomatic – proceed if it is practical to wait 2 hours for oral prophylaxis to be effective, or IV prophylaxis is given.
   - If not rebook UDS and ask patient to see GP to check dip/MSU 1 week prior, treat if positive and give prophylaxis for next time.
   - Make it clear to the GP and the patient that they need to make sure that the MSU result is known, and acted on as appropriate.

**Prophylaxis**

- Ciprofloxacin 750mg by mouth exactly 2 hours prior to procedure, unless ciprofloxacin resistant or ciprofloxacin in 6 months prior.
- In which case give fosfomycin 3g by mouth a minimum of 2 hours prior to procedure or,
- Or, give IV gentamicin 3mg/kg, within 1 hour of procedure.
- **NOTE:** IM gentamycin immediately before UDS DOES NOT give adequate prophylaxis

8.1.2 Paediatric, Bristol Children’s Hospital

**Bristol Children’s Hospital: Notes for use of antibiotics in paediatric urodynamics**

- dipstick testing of urine in asymptomatic children doesn’t contribute to decision making re proceeding with study
- urodynamics should be postponed in patients with symptomatic UTI
- the choice of prophylactic antibiotics can be guided by local antibiotic resistance profiles
- trimethoprim is reasonable 1st line prophylaxis [4mg/kg twice daily - started 24h before and continued for 24h after - unless history of resistant UTI]
- nitrofurantoin is reasonable 2nd line prophylaxis [0.75mg/kg four times daily - again 24h before and 24h after, if history of resistant UTI]
- gentamicin is preferable in theatre when suprapubic lines are inserted day before UDS [as it lasts 24h and will cover procedure]
- Parents should be made aware of symptoms, signs and plan if post-procedure UTI occurs [we have a leaflet, but it doesn’t currently include this advice]
8.2 Urodynamic Patient Leaflets

8.2.1 Adults, Bristol Urological Institute

[PDF]
Urodynamics_NET00
2646_0.pdf

8.2.2 Children, Bristol Children’s Hospital

[Video]
Urodynamics.pdf

8.2.3 Neurological patients, Sheffield Spinal Cord Injury Uni

[PDF]
VUD info sheet for neuropaths may 2011

8.2.4 Women, Leaflets from Birmingham Women’s Hospital, and St Mary’s Hospital Manchester

[PDF]
45 Gynaecology
Urodynamics Jun 2011 namc%20Studies.doc

8.2.5 Queen Elizabeth Hospital, Glasgow “After your test” leaflet

[PDF]
final_UDs after care info leaflet.doc

8.3 Bladder Diary and Male and Female Symptom Questionnaires

8.3.1 International Consultation on Incontinence Questionnaire – bladder diary

[PDF]
ICIQ-urinary diary - FINAL Post ad-board

8.3.2 International Consultation on Incontinence Questionnaire – male lower urinary tract symptoms (ICIQ-MLUTS)

[PDF]
ICIQ-MLUTS (UK English) 0106 - Sample

8.3.3 International Consultation on Incontinence Questionnaire - female lower urinary tract symptoms (ICIQ-FLUTS)

[PDF]
ICIQ-FLUTS (UK English) 0804 - Sample

8.4 Urodynamic reports for men and women, Bristol Urological Institute
8.5 Skills for health competencies: [www.tools.skillsforhealth.org.uk](http://www.tools.skillsforhealth.org.uk)

Skills for Health competencies relevant to urodynamics include:

- CC01 Assess bladder and bowel dysfunction
- CC02 Insert and secure urethral catheters
- CHS39 Assess an individual with a suspected health condition
- CHS40 Establish a diagnosis of an individual’s health condition
- CHS41 Determine a treatment plan for an individual
- CHS83 Interpret the findings of healthcare investigations
- CHS170 Develop clinical protocols for delivery of services
- CHS6.2012 Move and position individuals
- GEN2 Prepare and dress for work in healthcare settings
- GEN4 Prepare individuals for healthcare activities
- GEN5 Support individuals undergoing healthcare activities
- GEN6.2012 Manage environments and resources for use during healthcare activities
- GEN7 Monitor and manage the environment and resource during and after clinical activities
- GEN13 Synthesise new knowledge into the development of your own practice
- GEN36 Make use of supervision
- GEN39 Contribute to effective multidisciplinary team working
- GEN40 Contribute to the development of the multidisciplinary team and its members
- GEN62 Collate and communicate health information to individuals
- GEN63 Act within the limits of your competence and authority
- GEN77 Perform first line calibration on clinical equipment to ensure it is fit for use
- IPC1 Minimise the risks of spreading infection by cleaning and maintaining the environment
- IPC2 Perform hand hygiene to prevent the spread of infection
- IPC6 Use personal protective equipment to prevent the spread of infection
- IPC7 Safely dispose of healthcare waste, including sharps to prevent the spread of infection
- IPC9 Minimise the risks of spreading infection when removing used linen

Urodynamic specific competencies do exist but these need updating and are currently not available

8.6 Training and CPD details for Urodynamic Staff

8.6.1 Adult Urology

Urology trainees: the JCST’s Certification Guidelines for Urology state that, there should be evidence of competency with an appropriate number of procedures. For Urodynamics, this is an indicative number of 50 at Level 4 competency. (July 2017). As well as granting a CCT, it is required that urologists in training have attended a recognized urodynamic course

Competency for practical procedures is assessed via completion of Direct Observation of Procedural Skills (DOPS) and Procedural Based Assessments (PBA).

Competency is graded using the following scale:
- Level 0 – Insufficient evidence observed to support a summary judgement
- Level 1a – Able to assist with guidance (was not familiar with all steps of procedure)
- Level 1b – Able to assist without guidance (knew all steps of procedure and anticipated next move)
- Level 2a – Guidance required for most / all of the procedure (or part performed)
- Level 2b – Guidance or intervention required for key steps only
- Level 3a – Procedure performed with minimal guidance or intervention (needed occasional help)
- Level 3b – Procedure performed competently without guidance or intervention but lacked fluency
- Level 4a – Procedure performed fluently without guidance or intervention
Level 4b – As 4a and was able to anticipate, avoid and / or deal with common problems / complications

8.6.2 Paediatric urology:
Consultant

8.7.2.1 The maintenance of expertise requires regular practice and a sufficient workload
8.7.2.2 A workload of <30 children per annum would be inadequate to maintain expertise and these cases should be referred to a centre that is able to maintain that level of activity
8.7.2.3 It is recognised that in some highly specialised departments, which function in relative isolation from other services, it may be impossible to achieve the numbers suggested above. However, these highly competent departments will be able to demonstrate their expertise in other ways

8.6.2 Paediatric urology:
Trainee

8.7.2.4 Training must initially be given under the supervision of an identified preceptor. This should normally be for a minimum of 20 sessions if 2 patients are seen. It is anticipated that this would involve attending a regular session for a period of 6 months
8.7.2.5 Within the first 12 months of commencing practical training, the trainee should attend a relevant theoretical course
8.7.2.6 Written evidence of observations of clinical practice and formal testing of a minimum of 20 cases must be undertaken and completed to the satisfaction of preceptor before the trainee is deemed competent to practice unsupervised
8.7.2.7 Attendance at a regular MDT meeting to present and discuss interesting or challenging management of cases seen

8.6.3. Urogynaecology

8.7.2.8 Training is delivered as part of the RCOG Advanced Training Skills Module in Urogynaecology and Vaginal surgery
8.7.2.9 This involves direct observation of senior colleagues, attending 40 basic urodynamic investigations and completing a recognised course. Assessment is by log book, OSATS and CBDS. Full details can be found at: https://www.rcog.org.uk/globalassets/documents/careers-and-training/atsms/atsm_urogynaecologyvaginalsurgery_curriculum.pdf

8.6.4 Nurses
8.6.4.1 a nurse (Band 5) may be responsible for the technical aspects, working with a specialist nurse, doctor or clinical scientist responsible for the clinical aspects. During video UDS it may also be necessary to have radiology staff present
8.6.4.2 a specialist nurse (Band 6 and above), doctor or clinical scientist will be responsible for both the technical and clinical aspects of UDS
8.6.4.3 Working towards competence: minimum of 50 investigations or until deemed competent by the supervisor; minimum of 5 reflective accounts (supports revalidation process)
8.6.4.4 Job description should include delivery of urodynamic investigations
8.6.4.5 When competent: contribute to and attend local MDT meetings to discuss investigation traces as per clinical need
8.6.4.6 Clinical supervision and annual appraisal

8.6.5 Clinical scientists
8.6.5.1 In countries where the Scientist Training Programme (STP) is the route, clinical scientists divide into two subject groups: gastrointestinal physiology and urodynamic science AND clinical engineering. In particular, the clinical Measurement and ICT specialism, where the clinical measurement competencies would need to specifically include urodynamics. Both of these are formal, 3 year training programmes incorporating an appropriate MSc. They have ongoing assessment and an exit exam. At the end of both of these a clinical scientist would be eligible for HCPC registration, and competent in the technical and clinical skills outlined above.

8.6.5.2 Scotland: has sent trainees to STP, gastrointestinal physiology and urodynamic science, described above. For Clinical Engineering, the route is equivalence. They would thus be expected to have covered most of the competencies above.

8.6.5.3 There is still a route to Clinical Scientist involving none of the above namely, the ACS Route Two process. One would expect any such trainee to have accumulated the competencies shown above – and more.

8.6.6 Clinical Technologists

8.6.6.1 There is no formal training scheme for clinical technologists in urodynamics. Training would be via a local training plan, with sign-offs, containing many of the competencies already discussed.

8.6.6.2 CPD: one would anticipate: monthly MDT – including presenting cases; regular journal club; appropriate local annual meetings – e.g. SPFN; appropriate national annual meetings – e.g. UKCS