In the UK, faecal incontinence affects up to 10% of adults (National Institute for Health and Care Excellence, 2014) and about half a million adults cannot control their bowels properly (Bit.ly/ACPGBIBowel). As well as older people, faecal incontinence can affect many groups, such as women after childbirth, people who have had anal or colon resection, people with neurological conditions such as multiple sclerosis and people with connective tissue disorders such as Ehlers-Danlos syndrome.

People with faecal incontinence often live with their symptoms for a long time before seeking help. When they eventually do, they often have to undergo numerous tests, see multiple health professionals and face long waiting times before accessing or even accessing the treatment they need. Sacral nerve stimulation, which can improve control of the anal sphincter, is used when conservative treatment of faecal incontinence has failed. It involves a long patient pathway, including two stages of surgery. At Wythenshawe Hospital, a colorectal nurse decided to create a nurse-led sacral nerve service. Launched in June 2017, this service has considerably reduced waiting times and means patients are now treated by the same person throughout their entire pathway.

Establishing a nurse-led sacral nerve stimulation service

Key points

- Faecal incontinence affects up to 10% of adults in the UK
- Sacral nerve stimulation is used in faecal incontinence when conservative treatment has failed
- Sacral nerve stimulation involves temporary surgery followed by permanent implant
- Patients with a sacral nerve stimulation device need long-term follow up and support
- A nurse-led sacral nerve stimulation service can reduce waiting times and improve care continuity

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Abstract People with faecal incontinence often face long waiting times and numerous appointments with different health professionals before accessing the treatment they need. Sacral nerve stimulation, which can improve control of the anal sphincter, is used when conservative treatment of faecal incontinence has failed. It involves a long patient pathway, including two stages of surgery. At Wythenshawe Hospital, a colorectal nurse decided to create a nurse-led sacral nerve service. Launched in June 2017, this service has considerably reduced waiting times and means patients are now treated by the same person throughout their entire pathway.

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implanted under general anaesthesia (although some centres now use local anaesthesia and intravenous sedation).

In the test stage, a temporary wire connected to an external battery is placed through the S3 sacral foramen adjacent to the sacral nerve root. The wire is secured by adhesive dressing only, so to prevent displacement patients must avoid certain physical activities and showering. At a clinic appointment two weeks later, the wire is removed. Effectiveness is evaluated from the patient’s symptom diary and responses to the Manchester Health Questionnaire. Symptoms must have improved by at least 50% for a permanent implant to be considered.

In the permanent procedure, a foramen needle is placed into the S3 sacral foramen, a guidewire inserted and the needle withdrawn. A small incision is made to allow a dilator to be introduced. The guidewire is removed. At this point, the permanent wire is inserted using fluoroscopy, tunelled subcutaneously and connected to the battery, which is placed into a subcutaneous pocket in the upper buttock. At the next clinic appointment, the device is turned on and programmed.

**Nurse-led service**

At Wythenshawe Hospital, SNS surgery used to be performed in the main theatre department by consultants, with no regular dedicated SNS theatre sessions, but this led to long waiting times and cancellations during busy periods. Patients would often see a different health professional every time they came to hospital.

My plan was to have a dedicated nurse providing all care and treatment, from the first clinic appointment to follow up. The aim was to improve continuity of care, enhance patients’ experience and quality of life, reduce their stress and anxiety, and improve their relationships with health professionals.

I also hoped to reduce waiting times and cancellations by performing test implants outside the main operating theatre. Streamlining the service would hopefully reduce waiting times for the permanent implant, post-op programming and follow up.

**Setting up the service**

To provide the service I needed further training, so between 2015 and 2017 I undertook a master’s degree in surgical care practice in general surgery. This gave me the qualification to implant both the test and the permanent device independently. I believe I am the only colorectal nurse in the UK to perform both stages of SNS surgery.

One of the challenges was to find a suitable area in the hospital for the test implants, with staff able to help with the procedure and support patients. I visited other hospitals to observe their operating and recovery areas. I eventually found a small-procedures unit with dedicated nursing staff experienced in theatre work, where patients are supported throughout the procedure by the same team. There are reclining chairs and the atmosphere is more relaxed than in an operating department.

Procedure time and extra staff were negotiated with the unit manager, directorate management and consultants. Staff needed to be competent in handling the equipment so I trained them with help from a representative from the device manufacturer (Medtronic), who was also present during the first six surgery sessions.

I worked with the infection control department, estates department and supplier to check the airflow system was adequate for ventilating an area where medical devices would be implanted. The surgical pharmacist, consultant and I reviewed the trust’s patient group directives so I could give local anaesthetics to patients. My personal challenge was to ensure that consultants believed I was able to deliver the service.

“**This project pushes the traditional role boundaries of nursing practice**”

*(Judges’ feedback)*

**Outcomes**

The service started in June 2017. Every two weeks I perform first-stage surgery in the small-procedures unit and once a month there is a dedicated theatre session for permanent implants.

Waiting times for both procedures used to be around 15 weeks; now, they are two weeks for test implants and nine for permanent implants. Cancellations have also gone down and overall efficiency gains have been made by freeing up consultant time and theatre availability. Early feedback from patients is encouraging, most of them rating the service ‘outstanding’.

**Improving the service**

The battery in a permanent device needs to be replaced after five years. This is currently done under local anaesthetic in the main operating department and I would like to move this to the small-procedures unit.

I currently follow up around 300 patients with an SNS device and plan to launch a dedicated SNS patient support group – to my knowledge there are none in the UK. I would get them more involved in their care and help improve their wellbeing.

A joint pelvic floor clinic has been established in collaboration with a specialist physiotherapist, who gives patients support and advice when I am away. I have not yet been able to tackle the challenge of succession planning, as the range of skills required is very specific and the person is likely to need a long training period, which would need to be funded.

**Conclusion**

A major driver for change in the NHS is to make services more patient-centred. One way of achieving this is to create nurse-led services that improve patient pathways and free up doctors to focus on more complex cases. An increasing number of NHS services are becoming nurse-led, but this often happens locally and organically. The nurses involved have few examples to guide them. I hope that my experience of setting up and running a nurse-led SNS service might inspire colleagues, whether in continence services or elsewhere.

**References**


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