

NATIONAL AUDIT OF CONTINENCE CARE FOR OLDER PEOPLE: MEASURING CHANGE IN ACUTE HOSPITALS: TOWARDS INTEGRATED CARE.

Hypothesis / aims of study

Urinary incontinence affects some 10% of older people and 30 – 60 % of people in long-term care settings [1]. Faecal incontinence occurs in approximately 1 – 4% of community dwelling adults and up to 25% of people in institutional care. Both cause much individual distress, particularly to the sufferer but also to carers. The UK Department of Health report, *Good Practice in Continence Services (2000)* highlighted the need for proper assessment and management of the problem, identified a wide geographical variation in access to services and called for regular audit of services. In addition, the *National Service Framework for Older People (2002)* set the requirement that service providers should establish integrated continence services for older people by April 2004.

The Royal College of Physicians Clinical Effectiveness and Evaluation Department has developed measures for defining the quality of care in managing urinary and faecal incontinence and in 2005, carried out the first National Audit of Continence Care for Older People [2]. This audit found that whereas two-thirds of patients with a continence problem in primary care had documented evidence of a history, less than half of hospital patients had. A full basic examination for continence was performed for fewer than 50% of patients/residents in primary care, hospitals and care homes and that documented evidence of a full specialist examination was at best done in half of patients in secondary care. Specific treatment varied widely between care setting and condition, Primary and secondary care performed inadequately in all domains. Following the publication and dissemination of the data, sites were left to act upon their own findings and to complete the audit cycle, one year later, a re-audit was performed. This study examines the change in those quality indicators which are most relevant to the development and maintenance of an integrated service model, for those hospital trusts taking part in both cycles of audit.

Study design, materials and methods

Hospital trusts were identified from Binley's Directory and from the original cohort taking part in the initial audit. Information from hospital trusts participating in both audits (2005 & 2006) was used for this study. Services organisational data pertaining to the structure of an integrated continence service, as outlined in "*Good practice in continence services*" were used to compare between years. Descriptive statistics were used to illustrate the change between audits. Ethical committee authorisation was not appropriate for this audit.

Results

There were 126 acute hospital sites which contributed data to both rounds of audit. Of these, 119 provided organisational data. Figure 1 shows the proportion of trusts with a written policy for continence care and the elements present within that policy. Figure 2 shows the numbers of integrated continence services and personnel within each.

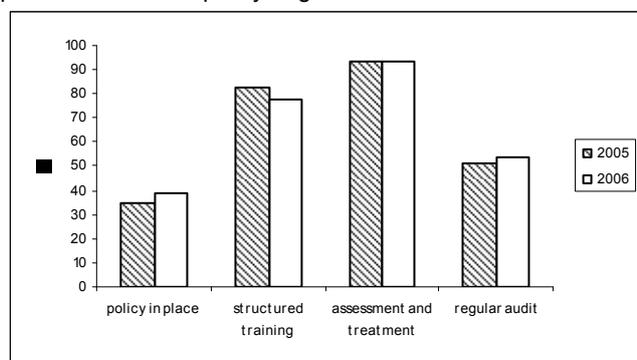


Figure 1. Policy and content

| | 2005 (%) | 2006 (%) | Change (%) |
|---------------------------------|----------|----------|------------|
| integrated service | 43 | 53 | +10 |
| clinical lead | 24 | 27 | +3 |
| policy | 35 | 39 | +4 |
| access to continence specialist | 64 | 69 | +5 |
| Integrated care path | 23 | 29 | +6 |
| referral to gynaecology | 55 | 66 | +10 |
| gastroenterology | 29 | 42 | +13 |
| geriatric medicine | 41 | 50 | +9 |
| colorectal surgery | 37 | 50 | +13 |
| urology | 59 | 75 | +16 |
| structured training | 54 | 56 | +2 |
| means for audit | 51 | 54 | +3 |
| case finding | 90 | 93 | +3 |
| basic assessment | 47 | 54 | +7 |

Access to diagnostic services was (2005 →2006) cystometry 86%→88%, urinary and GI tract imaging 81%→85% and anorectal physiology 38%→47%. A shift to community employed nurses was evident, however, the median wte for these services fell from 2.0 to 1.6 (IQR:0.5 – 3.0).

Interpretation of results

For most elements of the organisational audit there was an improvement in the proportion attaining the required standard. This is in line with the findings of other national audits [3]. Feedback suggested that this reflected an increased awareness of required standards because of conducting the audit and positive action to achieve them by hospitals. There was however, evidence of a reduction in the number of continence nurse specialists employed by the community available to Trusts, perhaps reflecting the financial pressures in the health service.

Concluding message

This audit has shown small improvements in the provision of services for incontinent older people.

References

1. Royal College of Physicians. Incontinence: causes, management and provision of services. The Royal College of Physicians, London. 1995.
2. National Audit of Continence Care for Older People 2005, Royal College of Physicians of London.
3. J R Coll Physicians London 1999; 33: 460 – 4.

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HUMAN SUBJECTS: This study did not need ethical approval because It is an analysis of a national clinical effectiveness audit and did not follow the Declaration of Helsinki - with approval by the ethics committee - in the sense that THIS is not a clinical trial. There is no direct intervention involving human subjects Informed consent was not obtained from the patients.