

UNDERSTANDING WHAT CONSTITUTES QUALITY CONTINENCE CARE FOR PEOPLE LIVING IN LONG-TERM AGED CARE FACILITIES

Hypothesis / aims of study

Prior research has drawn attention to deficits in the assessment and prevention of incontinence, and limited access to the full range of therapeutic options for people living in long-term aged care facilities (Watson 2003). In some countries, efforts to improve the quality of continence care in long-term care facilities have resulted in standards and quality indicators (QIs) that are linked to accreditation frameworks and funding (OECD/European Commission, 2013). Quality indicators are quantitative measures reflecting a professional care standard which are used as guides to monitor and evaluate the quality of important patient care and support service activities (Joint Commission on Accreditation of Healthcare Organizations, 2007). Existing QIs for continence care commonly measure the structure and/or processes of care, such as the percent of residents with a comprehensive continence assessment completed on admission, or the availability of a stock of continence products. Other QIs measure the outcomes of continence care, such as the percent of low-risk residents who lose control of their bowels or bladder, or the percent of residents with a urinary tract infection. However, it is unclear if these QI's accurately reflect consumers'/clients' understandings and expectations of quality continence care for people living in long-term aged care facilities. Prior methods to elicit this information were often based on researchers' preconceptions about 'quality' and questionnaires with fixed response options that did not provide contextual information to explicate the responses. Therefore, the aim of the study was to qualitatively explore residents', family members', staff, and continence practitioners' opinions about 'quality continence care' in long-term aged care facilities.

Study design, materials and methods

The research was conducted as a naturalistic inquiry using a qualitative exploratory descriptive research approach. The sample were purposively selected from anywhere in Australia and included 21 long-term aged care staff, seven continence practitioners with expertise in continence and aged care, five next-of-kin family members of aged care residents, and two aged care residents. The 21 long-term aged care staff included: seven Personal Care Workers, four Managers, four Registered Nurses, four Enrolled Nurses, and two Allied Health staff. Multiple methods were used to recruit participants, including a snowballing technique; selective placement of information in print and electronic media; and information sessions at facilities that expressed an interest in the study. Consenting participants were interviewed either in person or by phone for 20-45 minutes. They were asked to share their beliefs, opinions, understandings, expectations, and experiences about 'quality continence care' in long-term aged care facilities. Data were analysed using inductive content and thematic strategies to build constructions of 'quality continence care' for each stakeholder group. Two researchers independently read short segments of the transcribed interview text data to closely examine, interpret, code, and categorise the text. A coding matrix was then developed in which a researcher assigned one or more codes or labels to the text to describe what the data indicated. The codes and their content were repeatedly read, regrouped and recoded in order to delimit the overall number of codes and to ensure consistency and fit. Thereafter, independently coded data were compared and agreement reached.

Results

Long-term aged care staff

Managers' comments reflected a concern with organisational and regulatory constraints and disincentives for strategies to prevent incontinence and promote continence. They reported: contextually inappropriate continence assessment forms, gaps in education, resources; limited staff knowledge about ways to prevent and discuss incontinence; and limited options because of residents' high levels of dependence and complex care needs. Despite staff awareness of the need to promote continence, managers reported pads were often used as the first and only form of management. One manager expressed concern that residents would lose their mobility once they no longer walked to the toilet. Finally, decisions about residents' continence care were quite complex, because although managers wanted to promote residents' continence, they believed staff were not always able to implement documented care, such as toileting assistance programmes because of multiple competing priorities. They described doing the best they could with the resources available. Nurses' and personal care workers' comments centred on two key practices they believed would optimise residents' dignity: (i) using the right pad, checking the pad, and changing it at the right time, and (ii) providing toileting assistance at individualised times and on request. They cited staffing levels as a key barrier to providing toileting assistance, particularly at night. As staff placed considerable emphasis on containing and thereby concealing incontinence, residents' resistance to pads constituted a significant challenge that had to be managed.

Continence practitioners

Continence practitioners' perspectives about quality continence care varied according to their role, experience of working in a long-term aged care facility, and whether or not they had a family member in a facility. Having professional knowledge about best practice guidelines for continence and having a family member in a facility that did not adhere to these guidelines generated considerable tension between staff and Continence practitioners. Continence practitioners described struggling against ageist perspectives about incontinence, and having to modify their expectations of continence because of residents' high levels of cognitive and functional impairments, challenging behaviours, resource constraints, competing priorities, and deficits in staff education, and language and literacy issues. As such, they equated quality continence care with a reduction in the number and/or size of pads and an increase in the frequency of toileting. They also called for more staff to better meet residents' basic care needs, such as their need to be hydrated and receive timely toileting assistance; more education to enable staff to conduct comprehensive assessments and to develop and implement individualised continence care plans; and to interact with residents in ways that respect residents' dignity and personhood.

Next-of-kin family members

Family members' opinions about 'quality continence care' were linked to their beliefs about practices that dignify residents, i.e. using pads to make residents feel dry and comfortable, and providing timely and regular toileting assistance. Dignified continence care also equated to being cared for by staff who: conveyed compassion and empathy, offered choice, spoke in a calm manner, covered them during personal/continence care, checked, changed and discarded wet/soiled items discreetly, helped conceal their reliance on continence products, made them feel dry and comfortable, did not embarrass them, and recognised and responded to their need for assistance in a timely and sensitive manner.

Residents

The limited data from residents suggests an acceptance of incontinence, which was part and parcel of an overall acceptance of, and adjustment to being care-dependent.

Interpretation of results

The general acceptance of incontinence implied by the results, is at odds with best practice recommendations to promote optimal continence for all people. In the context of this acceptance, participants prioritised residents' social continence. Therefore, indicators of quality continence care centred on practices that participants believed would protect residents from visible uncontained incontinence, provide privacy, make residents feel comfortable, and on staffs' interpersonal skills when providing continence care.

Concluding message

A shared understanding of what constitutes 'quality of care' is central to improving consumers'/clients' experiences of health or social care. This qualitative study of four key aged care stakeholder groups, contributes to an understanding of consumers'/clients' experiences of, and expectations for residents' continence care. The findings highlight the need to tackle ageism in long-term aged care facilities, and to develop guidelines, standards and/or QIs for continence care that accommodate the context of care.

References

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