Peer review

Development of a multidisciplinary continuing care continence assessment tool and continence care pathway

Abstract

The Centres Promoting Health Independence (CPHI) – Improving Care for Older Persons project identified 10 domains of clinical practice imperative in the holistic care of the older person. The domain of managing and resolving incontinence issues was highlighted as a clinical problem area that can contribute to a patient's functional decline during hospitalisation. Continence nurse advisors (CNAs) have been aware that urinary and faecal incontinence issues are often poorly identified and managed in the continuing care wards. This paper is an overview of the project undertaken to address this issue.

The project had three phases. The first phase consisted of an open chart audit of patient medical records. Undertaken by a CNA, it determined how often incontinence was identified, assessed, diagnosed and appropriately managed by ward staff. Phase 2 developed a multidisciplinary, evidence-based best practice continence assessment and management tool (CAMT), to improve assessment, diagnosis and management of continence problems and facilitate patient-centred care in the continuing care wards. Phase 3 focused on testing the tool. Continence education and mentoring was provided to the ward staff and the tool was evaluated, via a staff survey.

This project identified gaps in clinical practice and led to changes in continence assessment, diagnosis and management by ward staff. Phase 3 identified barriers to staff using the new tool. The project fostered mentoring among clinical staff and has provided challenges in sustaining changes in practice.

Keywords: urinary incontinence, faecal incontinence, nursing assessment, evaluation

Introduction

Incontinence is not an inevitable part of the ageing process. Perpetuation of the myth that incontinence is inevitable with advancing years, and that little or nothing can be done to relieve symptoms or effect a cure, has been responsible for shaping many of the negative attitudes and beliefs held by society about older people and incontinence 1.

In the document Improving care for older people: A policy for Health Services, Victoria, it is stated that “… older people need to receive appropriate assessment and interventions based on best evidence to prevent the onset of incontinence or to effectively manage existing incontinence issues” 1. Continence care is an integral part of healthcare and screening for continence problems is important because its prevalence is high, its recognition is low, its consequences are great and the probability of successful management is high 1.

Continence service staff have been aware of anecdotal information that patients admitted to the continuing care wards with continence problems often have symptoms of incontinence poorly identified, assessed, investigated, diagnosed and treated. The Centres Promoting Health Independence
(CPHI) – Improving Care for Older Persons project allowed these concerns to be addressed systematically.

**Project description**

This CPHI project was undertaken in response to the perceived need to improve identification and management of incontinence among subacute in-patients. It was proposed that through identifying gaps in clinical practice and education of ward staff – medical, nursing and Allied Health – incontinence could be better diagnosed and treated.

The project occurred in three phases between March 2006 and July 2008. Phase 1 was an open chart audit of in-patient files in two rehabilitation wards to establish how patient continence status had been assessed on admission and what, if any, action had been taken. Phase 2 involved a review of the literature and development of a continence tool that was to be used by ward staff. Phase 3 was the implementation and testing of the tool by direct care staff and further evaluation. As this project involved an audit and staff education, it was established that formal ethics approval was not necessary. Approval and permission was sought and given by the Director of Nursing, Director of Allied Health, and the Medical Director.

**Project – Phase 1**

The aim of Phase 1 was to identify the prevalence of continence problems among subacute in-patients, compare quality of continence management to evidence-based best practice and to identify whether there was a need for improved consistency of continence management.

**Method – Phase 1**

The continence nurse advisor (CNA) (JP) completed an open audit of patient medical records on two wards. The tool used was based on the audit tool used in a National Audit of Continence Care for Older People 65 years and above, by the Royal College of Physicians, London. Some items were changed to reflect Australian state and federal government continence funding schemes.

The two in-patient units were rehabilitation wards and each had 30 beds. One was a movement disorders unit and, as such, had some younger patients. The other was a geriatric rehabilitation ward. Between March and May 2006 the medical records of current patients were reviewed, (including progress notes, referral letters and forms, and interdisciplinary assessment tools) for evidence of continence status pre-admission, relevant assessment, investigation and examinations, diagnosis of any continence problems, management and treatment, and discharge planning related to continence management. Results were collated into an Excel database for analysis.

**Results – Phase 1**

The results from both wards were similar and were, therefore, combined. Fifty-nine medical records (28 male and 31 female) were audited over a six-week period. The ages of patients ranged from the fourth to ninth decades, 25 were continent and 34 were incontinent pre-admission. Types of incontinence on admission were documented on transfer forms, geriatrician referral letters and the access unit form (completed by the intake unit).

All 59 medical records audited had information on patient continence status documented in the progress notes and each client had a bowel chart. Associated health problems, cognitive and functional status were documented but are not reported here. Healthcare workers who identified and documented incontinence symptoms were physiotherapists, occupational therapists, dieticians, social workers, nursing and medical staff. Within the 59 medical records audited, there were 21 different forms on which continence status could be recorded and there was some duplication of information collected.

The recorded examinations and investigations of 34 patients (of 59) with continence issues included:

- Abdominal examination – 3.
- Examination of perineum/pelvis – 3.
- Vaginal examination performed by the urologist at the urology clinic – 1.
- Lower limb oedema assessment – 2.
- Fluid balance chart monitoring intake of intravenous fluids only – 7.

Twenty-five patients were prescribed medicines that could potentially impact on their continence status and 13 of those 25 patients had their medicines reviewed. Post-void urine residuals (assessed using a bladder scanner) were performed on 17 of 34 clients with incontinence problems. None of the 28 men had the size of their prostate gland checked or a prostate-specific antigen (PSA) screening.

Forty of the 59 patients had urine tested on admission. Of the 34 patients diagnosed with urinary incontinence, a continence care plan was documented in 23 charts; however, these plans included items such as type of pad or indwelling catheter only. Nine patients had urinary incontinence and constipation identified. Six (five female) of the 34 clients had an indwelling catheter and two men used uridomes to manage urinary incontinence.

Sixteen (47%) patients with incontinence problems were managed with disposable continence products. Four patients, who were documented as being continent on admission, had the use of continence pads documented in their progress notes, but there was no documented information on their transition from continent to incontinent, assuming that this was the reason for the use of the pads.
In relation to discharge planning, 10 of 34 patients with continence problems had information in their record and two were referred to a urologist. There was no information in the charts to suggest that a referral to the out-patient continence service was discussed with the clients and their carers.

**Conclusion – Phase 1**

As with all retrospective paper chart audits, this project depended on accurate and complete documentation and could only take account of what was actually documented. It is possible that full assessment was completed but not recorded. The overall results from Phase 1 confirmed that continence problems are poorly recognised in the subacute in-patient population and this is substantiated by the lack of evidence of a continence history, examination, investigations, diagnosis and management plan.

On completion of the audit, a meeting was held with nurse unit managers and Registered Nurse Division 2 continence resource nurses from the two participating wards. The aims of that meeting were:

- To present and discuss the findings of the audit.
- To attempt to gain some insight into and identify why continence problems were poorly recognised and managed in the continuing care in-patient population.
- To develop recommendations for addressing these issues.

Reasons given for not recognising and managing incontinence problems included that the assessment tools were too varied and had inadequate questions about continence status. A common feature of many of the assessment tools found in the patient medical record was the use of a single tick box continence question that asked if the client was “continent of urine and faeces”. Such assessment tools provided no direction for formulating a diagnosis and appropriate management plan.

Two actions emerged as priorities: to develop a concise continence assessment tool, with a format that would enable ward staff to complete a continence assessment in approximately 30 minutes and to develop a continence care pathway (CCP), which would incorporate assessment, diagnosis and management of an identified continence problem.

**Project – Phase 2**

Phase 2 aimed to develop a continence assessment tool, incorporating a guide to formulating a diagnosis of the incontinence issue and a CCP. The tool was designed for use by multidisciplinary health professionals with general skills but not necessarily any specialist knowledge. Therefore, specialist skills in the field of continence care were not required since the basic steps in assessment, diagnosis and treatment were set out within the tool. This reduced the inequalities in knowledge levels making evidence-based continence care available to all patients.

**Method – Phase 2**

Phase 2 of the project required three steps as described below:

**Step 1**

A four-week trial of an assessment tool designed for residential aged care was undertaken to assess its suitability for subacute patients. A registered nurse division 1 and a registered nurse division 2, experienced in the subacute rehabilitation setting, conducted the continence assessments. Twenty in-patients, identified with symptoms of incontinence on admission, were assessed using this tool. The participating nurses noted the time taken and gaps in clinical questions at the end of each assessment. The nurses provided feedback at meetings with continence service staff.

**Step 2**

A literature search for evidence-based assessment, diagnosis and management of incontinence was undertaken. Papers in English language published from 1985 to 2006 were sourced using the databases Medline, CINAHL, Pubmed, Journals and books at Ovid, Clinical Health Channel, Clinical Evidence, and Cochrane reviews. Key search terms included: assessment or treatment; management; best practice; clinical guidelines; incontinence; bladder; bowel; urinary; faecal; stress; urge; constipation; and flow chart or care pathway. The search was widened to include reviews of continence clinical audit reports, health reports on continence in Australia and internationally and quality of life reviews in relation to continence and lower urinary tract symptoms. Additional literature such as Department of Human Services and Department of Health and Ageing policy documents, existing guidelines and relevant professional documents were also obtained. Examples of nursing assessment tools used by the wards and other specialist continence services were also collated prior to designing a draft continuing care continence assessment form.

**Step 3**

The draft continence assessment tool was tested over four weeks in the subacute wards, with a total of 20 continence assessments completed in the same method as Step 1. Limitations of the tool were recorded following patients’ interviews and notations were made about which items were confusing to the interviewer and the patient. The length of time taken for the assessment process was recorded. The assessment tool was then amended and the revised version circulated to continence service staff, for expert review, opinion and comment.

**Results – Phase 2**

**Step 1**

It was decided that the tool traditionally used in the in-patient units was not appropriate for the subacute rehabilitation model
of care as it only identified an incontinence problem without providing guidance on a diagnosis or management strategies.

Step 2
While the literature search revealed few relevant papers, a variety of continence assessment tools were found as well as the recommended content for such tools. The draft continence assessment tool was developed based on recommendations for a basic continence assessment from the literature 1-9. The quality of the draft tool was improved after identifying areas that were unclear, discussing and changing the format and wording, expanding categories and items, and incorporating feedback from colleagues and ward staff prior to the trial.

Step 3
During the trial phase of the draft continence assessment tool, the main feedback from nursing staff was that there was no direction given to assist in the formulation of a diagnosis or guide appropriate management strategies. A CCP was developed to provide a visual representation of the recommended steps in the assessment, diagnosis and management of continence problems and the order in which they should be considered.

A draft CCP was circulated to the Southern Continence Service staff, for expert opinion and comment, and amended accordingly. The final result was a continence assessment tool (including diagnosis and management) and CCP (Appendix 1).

Project – Phase 3
As a result of the recommendations for Phase 3 (Table 1) the focus of this phase was to pilot the draft continence assessment and management tool (CAMT) in three continuing care wards. The aim was to provide education and mentoring to all direct care staff to facilitate use of the tool and encourage evaluation of the tool as part of the process.

Method – Phase 3
Phase 3 of the project involved three steps.

Step 1
The draft CAMT was launched at two sessions and all staff associated with the wards were invited. A slide presentation and question and answer session informed healthcare staff of the tool and 40 copies were distributed with an evaluation form attached. We aimed to use a process evaluation approach. Participants provided feedback as to whether the project reached the target group, whether they were satisfied with the project, whether the activities were being implemented as planned and whether the educational components of the activity were of good quality 10.

Step 2
Eight education sessions at mutually convenient times were presented in each ward on the topics: general management strategies; stress incontinence; urge incontinence; urinary retention; functional incontinence; nocturia; constipation and a session on faecal incontinence. These sessions were presented as part of the regular, established, professional development programme and were round-table, information-sharing sessions at which relevant, evidence-based information sheets were available.

Step 3
The overall project was presented to the Continuing Care Executive members who included: the Director of Nursing, Director of Allied Health, Director of Medical Services, Director of Community and Subacute Rehabilitation Wards and Quality Improvement Manager.

Result – Phase 3

Step 1
Nurse unit managers, the Director of Allied Health, nominated continence resource nurses (division 2 nurse with the portfolio of continence management), and division 1 and 2 nurses from the three wards attended the launch. No medical or Allied Health staff attended.

Step 2
The education sessions, conducted by staff from the continence service, were well-attended with 10 to 12 participants, mainly registered nurses, at each session. However, apart from two medical students, no other disciplines attended the education sessions and night staff were unable to be engaged.

Six of 40 new continence assessment tool evaluation forms were returned, each completed by nursing staff. Of those, four nurses found the continence assessment tool took no longer than 30 minutes to complete and five found it easy to follow. Five found the physical assessment was easy to complete, a diagnosis was achieved and a management care plan could be easily created.

Table 1. Recommendations for Stage 3.

| 1.         | Pilot the CAMT plan in continuing care wards. |
| 2.         | Develop an education programme to be run in conjunction with the pilot programme. |
| 3.         | Establish a link/resource nurse in each ward to champion the change associated with the use of the new tools. |
| 5.         | Develop a continence discharge planning tool. |
| 6.         | Develop a continence resource folder for each ward. |
Four nurses considered they would have made the diagnosis without the form but three felt that it did assist with discharge planning.

Barriers to using the tool were assessed. It was identified there was a deficiency in communication because some staff on the wards reported they were unaware a pilot was under way. Some staff reported that continence assessment had a low priority because of workload. There appeared to be resistance to change as some felt they already managed continence care well and that it was the role of the CNA. Patient notes were not read retrospectively and staff were not always aware if a patient had a referral for continence issues.

Step 3
The Continuing Care Executive approved the submission of the assessment tool to Health Information Services to be included by the Clinical Documentation Steering Committee in the medical record of each patient.

Discussion
The development of a CAMT and a CCP was done in response to an audit that showed deficiencies in the management of continence issues in the continuing care wards and also at the request of nursing staff to have diagnosis and management components added to the form.

We then attempted to evaluate the use of these tools in the wards in which the tools were originally piloted. Overall, the efficacy of the project has been difficult to evaluate. Our experience confirms that of other authors who cite the main barrier to adequate continence care is competing workload demands that result in continence care being given comparatively low priority status.11

The clinical leadership model used for this project involved working with staff to help them introduce a new practice in response to their stated goals and to provide consultation and education along the way. For the duration of the pilot trial, the CNA was present on the ward only on a weekly basis. Although the use of the CAMT was poorly utilised, staff appeared genuine in their desire to improve continence management, but unable to sustain the momentum without more support. It was also disappointing that Allied Health staff, who also identify continence issues and are often responsible for many aspects of discharge planning, were not represented during Phase 3 of this project.

Practice development is a continuous process of improvement aimed at increased effectiveness in person-centred care and achieved through the enabling of healthcare teams to transform the culture and context of care. It needs to be supported by facilitators committed to a systematic, rigorous and continuous process of equal and even change, achieved through processes of education and up-skilling.12 Although the word ‘continuous' implies time passing, this type of change takes longer and needs more ongoing resources than a single project provides. We agree with McCormack et al.11 that practice development through the use of research evidence is not particularly easy and is definitely a slow process, but the rewards can be great for staff and patients. It is a process that must be undertaken despite the difficulties.

Conclusion
The outcome of this project shows an imperative for the appointment of a subacute in-patient CNA to provide expertise and education and to support, liaise and consult with nursing, medical and Allied Health staff so that the tool we developed becomes standard to ward practice across all continuing care subacute wards at our institution. It is recommended that the effect of this change needs to be evaluated using key performance indicators, such as tracking cost centre savings for the use of continence products, use of medicines and a follow-up audit in 12 months time.

References