Auditing continence services

People of all ages can be affected by incontinence. However, it is older people and those with chronic diseases such as diabetes or those who have heart failure who are more likely to experience continence problems.

Families who care for older people may find incontinence very distressing and the condition is often the factor that makes them seek long-term care for their relative (Ouslander, 1993).

Primary care carries most of the costs of incontinence and these are set to rise as the NHS now has to pay for absorbent products for people living in nursing homes (Department of Health, 2001; Continence Foundation, 2000).

Efforts are often concentrated on the containment of incontinence rather than investigating and treating it. In hospitals, older people are sometimes encouraged to wear a pad 'just in case' or are inappropriately catheterised.

Sometimes, continence assessment by district nurses and nurses working in care homes focuses on selecting the appropriate absorbent pad rather than treating the condition.

Managing continence services Incontinence is a symptom that requires investigation and treatment. In 70 per cent of cases, it can be cured (Royal College of Physicians, 1995).

In 2000, the Department of Health published the document Good Practice in Continence Services, which featured four key recommendations:
- Identify people with incontinence at GP practice level;
- Provide continence assessment in primary care;
- Develop integrated continence services with agreed procedures and protocols for diagnosis and treatment in primary, secondary and tertiary care;
- Develop comprehensive services that cover urinary and faecal incontinence for children and adults living at home and in care homes. This can be achieved by utilising the skills of professionals, people with incontinence and carers.

However, as this was not a national framework, health care providers were not obliged to implement the report’s recommendations.

National Service Framework for Older People

In 2001, the DoH published the National Service Framework for Older People (DoH, 2001). The following standards of the framework are relevant to continence:
- Standard 2 requires health care providers to provide integrated continence services;
- Standard 3 requires providers to offer rehabilitation and prevent premature or unnecessary admission to long-term care;
- Standard 4 requires hospitals to deliver appropriate specialist care;
- Standard 5 addresses stroke rehabilitation;
- Standard 6 addresses falls.

Although all health care organisations are required to meet the standards included in the framework, there are currently still unacceptable variations in the quality of continence services.

Some acute trusts do not have continence advisers, some concentrate on younger people, while others have well-developed, inclusive services.

Commission for Health Improvement (CHI)

This commission is responsible for setting standards of health care, auditing compliance and ensuring improvement of services. CHI plans to audit continence care next year and has asked the Royal College of Physicians to form an expert group to draw up audit tools and standards.

The group consists of representatives from care homes, the RCN, continence advisers and doctors specialising in continence care. The group has drawn up research-based audit tools to enable auditors to check on clinical care and the organisation of care in primary and acute settings.

The clinical care audit in primary care will check the number of patients on a GP’s list and record how many are aged 65 or over.

The continence care audit will record how many patients present with symptoms of incontinence, the number of catheterised patients and how many are referred for specialist assessment.

The organisational audit will check that there are policies and procedures in place for training staff, assessing and treating patients, and auditing services. These auditing tools are now being piloted and will be adapted if the pilot shows that this is necessary. CHI is currently contacting health care providers to ask if they wish to take part in the large-scale pilot of the tool. The commission will begin to audit continence services nationally next year.

Conclusion Continence care is an integral part of health care. CHI’s incorporation of continence within its inspection process will raise the profile of continence care, highlight organisations that offer an excellent standard of care, and encourage all health care providers to place continence at the centre of their service provision.

REFERENCES