MANAGEMENT AND PROMOTION OF CONTINENCE IN REHAB SETTINGS

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Approaches to continence care tend to focus on safety and risk reduction, rather than individualised assessment and management. This study, part of a larger one on continence care, revealed a lack of specific continence assessment and rationale for treatment or care decisions. The focus was on containment rather than on proactive management. Strategies should focus on developing person-centred and evidence-based approaches to continence promotion and management.

INTRODUCTION
Both urinary and faecal incontinence are associated with institutional care and, in particular, with dependence on physical care. Stroke survivors are reported to be particularly affected (Brittain et al, 2006). There is ample evidence (Sarkar and Ritch, 2000) that bowel care and attention to factors such as hygiene, diet and fluid intake can improve and restore urinary continence for many patients. It has been suggested that simple measures such as improving toilet facilities and removing environmental barriers may resolve the problem of incontinence (Williams, 2004). For example, effective management of ward furniture and equipment would improve access to toilets. However, there is evidence that incontinence continues to be inadequately diagnosed and managed (Coffey et al, 2007).

This study was conducted as part of a larger two-year case study, which aimed to identify the determinants of practice context that enable or hinder the promotion of continence and treatment of incontinence. Other aspects of the larger study are reported elsewhere (Coffey et al, 2007).

AIMS
The objectives of this smaller study were:
- To identify and describe urinary and faecal incontinence assessment, diagnosis and management in two rehabilitation settings for older people;
- To examine whether resources are available for staff and patients to enable continence promotion and management.

METHOD
Permission to carry out the study was granted by ethics committees at both sites. The research instrument used was the Royal College of Physicians’ audit scheme. This included a three-part patient questionnaire containing separate records for urinary incontinence, faecal incontinence and urethral catheterisation. A second questionnaire recorded the resources available for continence promotion and management in each unit. Data was collected by researcher-administered questionnaires and a review of patient records.

Sample
The research was conducted simultaneously at two similar rehabilitation units for older people (a 78-bed unit in Northern Ireland and an 80-bed unit in the Republic of Ireland). All patients identified by nursing staff as incontinent and capable of providing informed consent were asked to participate. Those who were acutely ill or unable to provide informed consent were excluded.

Data was collected over six months from 220 patients (130 from site 1; 90 from site 2).

RESULTS
Approximately 40% of participants were men and 60% women. Their mean age was 80 years. Participants in both units reported similar types of incontinence – over 60% had problems of urinary incontinence only, 3% suffered from faecal incontinence only and the remainder reported both urinary and faecal incontinence.

Nursing records of urinary incontinence were maintained in both units. However, the type of record and extent of assessment varied. There were very similar findings in both units – approximately 60% of incontinence assessments were recorded as general nursing notes in care plans, with only occasional use of specific continence assessment records (in approximately 9% of assessments).

The most common investigation recorded into the cause of incontinence at site 1 was
midstream specimen of urine (MSU) to rule out infection (45% in unit 1; 33% in unit 2). Residual urine measurement was also common in site 1 (24%) but not in site 2. In unit 1, 89% of patients were referred to a medical specialist for further investigations such as blood tests for prostate-specific antigen (PSA), cytology, renal ultrasound and ultrasound of abdomen, bladder or pelvis. However, in unit 2, only 2% of cases were referred to a nursing or medical specialist.

Treatment for urinary incontinence in both units mainly involved treatment for constipation (47%) and for urinary tract infection (43%). Eight per cent were treated pharmacologically (for example, anti-cholinergic medication for detrusor instability). However, over 85% of patients in both units remained incontinent following treatment.

Timed voiding was described by over 50% in both units as a continence management strategy. Incontinence pads were used for containment in just 50% of patients in unit 1, in contrast to 87% in unit 2.

Patients in both units reported a lack of specific communication with them regarding continence. In unit 1, for example, 62% indicated that continence problems were not discussed with them or their carer; the percentage was even higher (97%) in unit 2. In approximately 85% of cases there was no evidence of discussion on continence issues in patients’ records.

According to patient records, the management of faecal incontinence took the form of advice on laxatives, dietary changes and prevention of constipation. A number of patients were referred to a dietitian. However, in most cases faecal incontinence persisted (77% in unit 1; 89% in unit 2).

Resources for the promotion and management of continence

Written guidance on continence management was available to staff in unit 1, with the exception of guidance on indications for referral to urodynamic assessment, medical/surgical or continence nurse specialists. This was under review at the time of the study. No guidance on continence care or promotion was available to staff in unit 2.

While a nurse-led continence advice service was available to staff in unit 2, this was not in place at the time of the study in site 1, although a regional continence adviser had been accessible in the past. There was no ongoing continence education and training in either site. Information leaflets on continence promotion were available to staff and patients in both units but not displayed prominently.

DISCUSSION

The findings indicate that the focus of continence management was on containment rather than proactive management. The results are similar to those of a national audit of continence care in the UK, which reported that continence was under-assessed and under-treated (Wagg et al, 2006). Despite a government requirement for integrated continence services, this audit found continence care remained a neglected area.

This study was conducted in two rehabilitation units for older people where a large proportion of patients are post-stroke. The findings are of particular concern as incontinence is a common problem post-stroke (Brittain et al, 2006). It is also known that outcomes are more positive in patients who remain continent or regain continence quickly. There are therefore significant clinical implications of not dealing with incontinence appropriately in the rehabilitation setting. Recovery post-stroke can be hampered, leading to higher admission rates to long-term care and higher mortality.

The diagnosis and treatment of incontinence in both units was limited and this also has major implications for nursing practice. The potential for skin breakdown and damage is maximised with continuous exposure to urine and faeces, leading to poorer outcomes. Furthermore, patients also suffer psychologically from incontinence.

It is of concern that most patients in this study reported that incontinence was not discussed with them. According to Williams (2004), most patients welcome a healthcare professional broaching the subject with them because they may have been embarrassed about it and may not have been aware that help was available.

To ensure a person-centred approach to continence care, best practice guidance should be available as a resource for staff. A significant finding in this study was that outcomes are more positive in patients who remain continent or regain continence quickly. There are therefore significant clinical implications of not dealing with incontinence appropriately in the rehabilitation setting. Recovery post-stroke can be hampered, leading to higher admission rates to long-term care and higher mortality.

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