National audit of continence care for older people: management of faecal incontinence

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Abstract

Introduction: faecal incontinence in older people is associated with considerable morbidity but is amenable to successful management. Quality standards in this area were previously subject to a pilot audit in primary, secondary care and care homes to allow providers to compare the care delivered by their service to others and to monitor the development of integrated continence services as set out in the National Service Framework for Older People. This study reports the results of the national audit.

Results: data were returned by 141 primary care sites, 159 secondary care trusts (involving 198 hospitals) and 29 care homes. Data on the care of 3,059 patients/residents with bowel problems were analysed. Fifty-eight per cent of Primary Care Trusts (PCTs), 48% of hospitals and 74% of care homes reported that integrated continence services existed in their areas. Whilst basic provision of care appeared to be in place, the audit identified deficiencies in the organisation of services and in the assessment and management of faecal incontinence.

Conclusion: the results of this audit indicate that the requirement for integrated continence services contained within the National Service Framework for Older People has not yet been met. Basic assessment and care by the professionals directly looking after older persons is often lacking. There is an urgent need to re-establish the fundamentals of continence care into the daily practice of medical and nursing staff, and undoubtedly, action needs to be taken with regard to the establishment of truly integrated, quality services in this neglected area of practice.

Keywords: faecal incontinence, older people, audit, clinical effectiveness, elderly
Introduction

Faecal incontinence occurs in up to 10% of older people living at home and approximately 50% of nursing home residents. It is a vastly under-reported problem that has a major impact on quality of life and is associated with an increased mortality in sufferers [1–5]. It is suffered in silence, leads to loss of independence and causes social isolation, but most cases can be treated [6, 7]. There are, therefore, great opportunities for improving the lot of older people if this condition can be better understood, assessed and managed. For carers, faecal incontinence has an equally negative impact on quality of life and this burden may be the problem that leads to placement in institutional care [8, 9]. For health and social services, there are considerable costs for containment and care. Good Practice in Continence Services (2000) highlighted the need for proper assessment and management, identified a wide geographical variation in access to services and called for a regular audit [10]. The National Service Framework for Older People (2001) required the establishment of integrated continence services for older people by April 2004 [11]. However, there has been only limited action towards this, and provision of services remains extremely variable [12].

The Royal College of Physicians Clinical Effectiveness and Evaluation Unit (CEEU) has developed measures for defining the quality of bladder and bowel care, and a comprehensive audit package for continence care in older people in primary, secondary and care home settings [13–18]. In 2005, the Healthcare Commission commissioned a National Audit of Continence Care for Older People. This paper presents the results with respect to faecal incontinence.

The aims of the audit were to improve care for older people with continence problems; to demonstrate variation in standards of care relating to continence problems across different healthcare settings and to enable them to compare the quality of their care compared to evidence-based criteria, as well as to monitor the National Service Framework for Older People milestone for integrated services.

Method

Audit tool development

Full details of the audit tool have been published elsewhere [19] but briefly, standards for care were derived from pre-existing work and government publications, and then further developed by a multidisciplinary steering group and a wide range of professionals with expertise within, and related to, the continence field. The groups included representation from patients’ organisations and the charitable sector. The indicators were further validated by a Delphi process involving 100 expert clinicians. A separate work stream, elucidating patients’ views on the quality of services added patient defined standards [20]. The resulting package was piloted and modified prior to the National Audit [21]. The indicators covered aspects of the organisation of service provision and care.

Patient inclusion and data retrieval

The audit studied all those aged 65 years and over with faecal incontinence as defined by the clinical record. In acute hospitals, patients were identified from current inpatients (e.g. medical, elderly, surgical, long-term care wards). Data were extracted from all relevant clinical case records. In primary care, patients were identified from the records of a single GP practice designated to take part by their Primary Care Trust (PCT). Data were obtained from the practice records and computer systems, district nursing notes and continence advisor/specialist records.

In care homes, residents were identified within the participating care home and with data obtained from clinical records.

Recruitment of sites

The audit included England, Wales and Northern Ireland. PCTs and Local Health Boards in Wales were identified from Binley’s Directory of NHS Management and each asked to identify one of their GP practices for the audit. A total of 326 invitations were sent and 179 registered an interest to participate. For secondary care, all acute NHS Trusts were identified, 196 invitations were sent, and 175 trusts registered their interest to participate. Major care home providers were also invited, with a target total of 100 homes, for which 309 invitations were sent and 85 registered.

Recruited sites attended regional workshops (Liverpool, Leicester, Leeds, Bristol and London) for training on the use of the audit tool prior to data collection, and 421 delegates attended.

Data were submitted via the Internet (using Internet Explorer v5.0 or above for Windows 98 and later versions) to a securely hosted website. All submitted data were anonymous and no part required patients or their carers to be contacted. Help buttons were provided online alongside the questions and a help booklet was also issued to participants. Each site completed one organisational form and returned data on 10 patients with faecal or double incontinence. Each participant was asked to independently audit their first two cases to conduct a reliability study.

Data are expressed in percentage and absolute terms and where data were not applicable the denominator was adjusted accordingly. The audit designated a priori specified circumstances where measures did not apply. Missing data was regarded in the negative for the measures in this audit. Analyses were performed within the CEEU using SPSS v11.5.
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Results

Data were returned by 141 (43%) primary care sites, 159 (81%) secondary care trusts (involving 198 hospitals) and 29 (9%) care homes that were invited to participate, and concerned data from 999, 1,799 and 261 clinical records respectively.

Reasons for withdrawal after registration were known for 22/38 primary care sites, 11/16 trusts and 19/56 care homes. The main reason given was lack of resources (staff shortages, annual, or sick leave, unforeseen changes to, or reduction in, staffing or change in management). Other reasons given by PCTs were difficulties in involving a GP/practice (3), too few cases (2), continence services shared with another PCT (5) and audit time frame too tight (3). Those given by secondary care trusts were lack of motivation (3), too many national audits (2), mistaking the audit timings (1) and audit material not getting to the right person (1). Reasons for care homes included lack of or limited access to the Internet (3), audit time frame too tight (3) and difficulty with postal delivery (1).

The electronic input method guaranteed that missing data levels (i.e. ‘blank’ entries) were very low (less than 1%). The audit tool proved reliable with kappa values of 0.60 and higher dominating the results (Table 1).

Organisation of care

Fifty-eight per cent of PCTs, 48% of hospitals and 74% of care homes reported that integrated continence services existed in their areas (Table 3). Seventy-five per cent of PCTs, 90% hospitals and 100% care homes had a policy of routinely asking patients about bowel problems and there was widespread availability of specialist continence advice; 97% to PCTs, 90% to hospitals and 96% to care homes with a median of 1.8 (primary care), 1.6 (hospitals), 1.0 (care homes) being available to each sector.

Continence services within hospitals were least developed, only 32% having a written policy, 49% having a structured training programme and 35% performing regular audit of their services (Table 2, Fig. 1). Specialist continence assessments were performed by staff trained to carry out abdominal, vaginal and rectal examinations in only 54% of hospitals.

All audit sites reported that privacy and dignity was maintained to a very high degree (95% in PCTs, 87% in hospitals and 100% in care homes).

Patients

The mean age of patients/residents was higher in hospital and nursing care than in primary care (mean 82, 84, 81 (SD 8) years). The majority of the sample for which data were available had high levels of cognitive and functional impairment which differed substantially between the three sectors—cognitive: 32% (primary care), 59% (hospitals), 84% (care homes); functional: 36% (primary care), 77% (hospitals), 75% (care homes).

In each setting the most common associated comorbidities were urinary incontinence, stroke, dementia and impaired mobility.

Process of Care

Documented evidence that a history had been taken was reported in approximately 50% of patients within each care sector (variation 45–63%). Details of examination were poorly recorded. Only 22–33% of patients had a recorded basic examination (history and rectal). When a specialist examination was carried out only 42–54% of patients had this documented and only 32–59% of patients had documentation of an examination of the perineum and anus, whilst 12–28% were screened for malignancy.

A documented cause for bowel disorder was noted in only 27–49% of cases; 27% being in hospital care. Table 3 shows the treatment either given or planned. There was considerable variation in the documentation of a management plan with high levels in care homes (76%), much lower levels in hospital (36%) and 57% in primary care. In 40% (308/767) of appropriate primary care and 17% (170/980) of appropriate hospital cases there was evidence that cause and treatment had been discussed with the patient.

Discussion

The purpose of this audit was to allow those involved in managing continence in the elderly to compare their service and quality of care to evidence-based standards, to monitor the National Service Framework standard for the introduction of integrated services and compare results with similar organisations. This is the largest and widest study of continence care in the United Kingdom and provides a picture of care in primary care, secondary care and selected care homes.
Table 1. Summary of findings in reliability analyses

<table>
<thead>
<tr>
<th>Audit</th>
<th>Primary care</th>
<th>Secondary care</th>
<th>Care homes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faecal continence</td>
<td>88 variables</td>
<td>94 variables</td>
<td>75 variables</td>
</tr>
<tr>
<td>Kappa median</td>
<td>0.80</td>
<td>0.67</td>
<td>0.84</td>
</tr>
<tr>
<td>Kappa IQR</td>
<td>0.73–0.88</td>
<td>0.59–0.78</td>
<td>0.71–1.00</td>
</tr>
<tr>
<td>218 patients (112 sites)</td>
<td>318 patients (158 sites)</td>
<td>40 patients (21 sites)</td>
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</tr>
</tbody>
</table>

IQR, Inter-Quartile range.

Table 2. Organisational indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Primary care</th>
<th>Secondary care</th>
<th>Care home</th>
</tr>
</thead>
<tbody>
<tr>
<td>N %</td>
<td>N %</td>
<td>N %</td>
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Integrated services
- Is there access to an integrated continence service | 79/137 (58) | 94/195 (48) | 20/27 (74) |
- Is there a lead person for integrated continence service | 53/79 (67) | 67/94 (55) | 10/20 (50) |

Continence specialists
- Do patients have access to a local continence specialist | 134/138 (97) | 175/195 (90) | 26/27 (96) |

Screening
- Is it the facility’s practice to ask a screening question rebladder/bowel care as part of the initial assessment | 104/138 (75) | 176/195 (90) | 26/26 (100) |

Management
- Does the facility have a written policy for the management of continence | 81/138 (59) | 63/195 (32) | 25/27 (93) |
- Does the facility use an integrated care pathway | 54/138 (39) | 47/195 (24) | 3/26 (12) |
- Is there a written protocol for providing a basic assessment for all people who indicate that they have a bladder and/or a bowel problem | 89/138 (64) | 85/195 (44) | 23/26 (88) |

Staff
- Is there a structured programme of staff training on promoting continence | 97/138 (70) | 96/195 (49) | 17/27 (63) |
- Does the training programme include basic assessment | 93/97 (96) | 87/96 (91) | 11/17 (65) |
- Is specialist continence assessment carried out by a practitioner with training in abdominal, rectal and vaginal examination | 86/138 (62) | 105/195 (54) | 11/27 (41) |

Privacy and dignity
- Do areas for both assessment and treatment preserve patients’ privacy and dignity | 128/138 (95) | 169/195 (87) | 27/27 (100) |

Audit
- Is bladder and bowel care delivered subject to regular audit | 73/119 (61) | 55/155 (35) | 14/22 (64) |

Information
- Is evidence-based information about bladder and bowel care freely available to some or all patients and carers | 118/137 (86) | 151/192 (79) | 23/27 (85) |

Participation levels were encouraging, with different considerations affecting the three different settings.

Hospitals
Most hospitals were able to complete the audit and an impressive 81% returned the data. Cases were identified by audit departments and clinical staff with an interest in continence care and should have been consecutive cases, but this may not have been as rigid as would have been ideal. Some sites reported difficulty in accessing appropriate records and may therefore have submitted a small sample of patients that was not truly representative of their normal case mix. Nevertheless, the data are likely to be generally representative of care in the hospital sector.

Primary care
We were pleased with the level of participation from primary care; this may reflect the budgetary importance of continence care and that Continence Advisors were the professional group most motivated to carry out the audit. Only one practice per PCT was nominated to take part and thus the results may not be generalisable to the whole area.

Care homes
It was particularly difficult to recruit care homes, and those that were recruited often had difficulties with data collection. This highlighted the challenge of carrying out audit in settings where resources, staffing and culture do not routinely allow it. A lack of access to a single central set of records, limited information technology and staff shortage was often cited as a contributing difficulty. In addition many homes noted that faecal incontinence was assessed prior to admission and that the role of care home staff was to enact a management plan rather than reinvent the assessment process.

It is then, important to take account of case mix variables in comparing services from the three healthcare settings.

These data confirm the very common nature of faecal incontinence in older people in hospital and in care homes.
In this sample, for example, faecal incontinence was a daily occurrence for over half of patients/residents and was, in the majority, complicated by associated co-morbidity. The reported organisation of services suggests a reasonable basic provision of care, particularly within primary care, although the audit did not cover a random selection of practices. Although 48–74% report access to an integrated service, many had missing elements which would make up such a service suggesting that this was an optimistic view. The ultimate goal of integrated services contained in the National Service Framework for Older People has not been met. Most, however, reported access to a specialist continence advisor and claim to ask routinely about bowel problems. Unfortunately, a positive response did not guarantee an assessment for the problem in many sites. Although we can be reasonably confident about the validity of data extracted from clinical records, the robustness of self reported activities, such as audit and user involvement could be questioned. However, we did ask for, and receive many continence policies and checked these for quality. This exercise gave us some confidence in the received data.

The reported availability of specialist continence advisors was encouraging in each sector. The median of 1.6 continence advisors per trust represents approximately 1 continence advisor per 165,000 population or per 26,500 population over 65 or about 2,500 with faecal incontinence. The DoH Guidance ‘Good Practice in Continence Services’ was laid out in ‘Good Practice in Continence Services’ was inadequate (specialist examination was defined as anything beyond taking history and performing a rectal examination). Even more detailed assessments did not include examination of the perineum and anus, and still failed to include a rectal examination. At the simplest level, if constipation and rectal loading are not assessed, the commonest and most treatable cause of faecal incontinence will be missed. Importantly, a clear cause for the identified faecal incontinence was rarely documented and without a known cause, evidence based, effective treatment could not be provided. All too often, management relied on containment rather than cure.
Faecal continence care for older people

Of course, there may have been marked differences in what was actually done for patients and that which was documented. However, it is unlikely that key elements of the examination are routinely not documented and thus the audit is likely to reflect actual practice in these areas.

This audit shows that the requirement for integrated continence services contained within the National Service Framework for Older People has not yet been met. Services are reliant upon the input from specialist continence advisors at the expense of basic assessment and care by those directly looking after the older person. There is an urgent need to re-establish the fundamentals of continence care into the daily practice of medical and nursing staff and action needs to be taken with regard to the establishment of truly integrated, quality services in this neglected area of practice. If specialist continence services are to cater for the needs of all with continence problems then there is a large resource problem, particularly in the light of the current financial state of the NHS, which has resulted in a withdrawal of continence care in some areas of the country. The cost of continence care is high, whether measured in health care resource use or financial terms; high quality evidence-based care should be able to manage these, reduce the considerable associated morbidity and ensure that financial costs are based on rational decisions.

Key points
- The 2004 milestone of integrated services contained in the National Service Framework for Older People has not been met.
- Assessment of faecal incontinence as laid out in ‘Good Practice in Continence Services’ is inadequate.
- Services are reliant upon the input from specialist continence advisors at the expense of basic assessment and care by those directly looking after the older person.

Conflicts of interest
The authors have no conflict of interest pertaining to this paper.

The study was funded by the Healthcare Commission, which had no editorial control over the writing of this paper.

References

Received 15 August 2006; accepted in revised form 14 December 2006