



# Changing Practice in Continence Assessment

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## Project team:

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## Summary of project

This pilot project was initiated and carried out by members of a medicine of the elderly continence clinical improvement group. Nurses working in one ward in a hospital specialising in the care of older patients were involved in a practice development project in order to change practice in continence assessment. This project utilised multidisciplinary focus groups, educational tools such as workshops and role play, change management strategies and ongoing facilitation. The project was able to react to many challenges faced whilst implementing changes in practice in the clinical area. For example, the continence assessment tool was incorporated into the pre-existing multidisciplinary team sheet rather than being issued as a 'stand alone' document. This meant that the components of the continence assessment were more likely to be documented. Success of the project has been determined through eliciting the reflections of the ward-based multidisciplinary team.

## Background

A third of all elderly patients being nursed within a hospital or institution may present with urinary incontinence (Royal College of Physicians, 1995). The impact of urinary incontinence on patients being cared for in a hospital setting has not been well investigated.

A local study surveying the views of nine physiotherapists working within The Royal Victoria Hospital in Edinburgh confirmed the findings of Coleman Gross (2003), namely, that it can significantly affect patient's ability to concentrate on, or partake in rehabilitation programmes. The main reasons for this cited by the physiotherapists related to time lost within therapy sessions to take patients to the toilet and clean up any incontinent episodes. Furthermore, the patient's high anxiety level of possible incontinence led to a less productive treatment session.

The views of patients who had a problem with urinary incontinence were also elicited within this study and are outlined in Box 1. Their thoughts and feelings on the impact of incontinence were obtained as the result of a general discussion on the topic rather than using questions from a formal Quality of Life measurement scale.

### Box 1: Patient's views about the impact of incontinence

- Embarrassment
- Resignation
- All encompassing
- Worry
- "Why me?"
- Unwilling to do therapy due to incontinence

There have been a number of guidelines published recently (See Box 2) that seek to support the role of the multidisciplinary team in promoting continence. Two audits performed in Liberton, Royal Victoria, Western General and Royal Infirmary hospitals have only reinforced the results of previous studies (Cheater 1992, 1993; Irwin, 2001). These baseline audits were conducted in order to assess nurse's knowledge and attitudes towards continence assessment using Cheater's (1992) original questionnaire, and to determine if there was evidence of a continence assessment being performed on patients deemed to be incontinent of urine on admission to hospital, or during the course of their hospital stay. The audits found that the nurses lacked knowledge on the continence assessment process; they did not perceive that they were the key people in continence restoration; and key components of a continence assessment were not being initiated.

The literature has shown education programmes in relation to continence assessment do not change nursing practice (Connor and Kooker, 1996; Rigby, 2003). This reinforced the challenge facing the project team and supported the requirement for an innovative approach to be taken.

### Box 2: Guidelines relating to assessment, diagnosis and management of urinary incontinence

- Good Practice in Continence Services, Department of Health (2000)
- Continence: Adults with Urinary Dysfunction, Best Practice Statement, QIS Scotland (2002)
- Essence of Care-Patient Focused Benchmarking for Health Care Practitioners
- Department of Health (2001)
- Management of Urinary Incontinence in Primary Care, SIGN – Scottish Intercollegiate Guidelines Network (2004)

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## Aims and objectives of the project

The overall aims of the project were:

- To enable members of the multidisciplinary team to undertake an assessment of patients who are incontinent of urine
- To establish a change process that could be used to promote best practice in continence assessment

Within these aims, the following objectives were identified:

- To identify the barriers that prevent the multidisciplinary team assessing patients who are incontinent of urine
- To develop an educational programme that focuses on the specific requirements, as identified by the nurses working in the project ward
- To implement realistic and achievable changes in practice identified by the nurses in the project ward
- To provide the appropriate support mechanisms to enable changes in practice to occur
- To introduce documentation to support the change in practice and enable it to be audited
- To evaluate changes in practice that have occurred

## Methods

### Survey of nurses in project ward

A simple questionnaire was sent to the nurses in the project ward to identify their educational requirements and highlight the barriers that prevented patients with urinary incontinence being assessed. A staff nurse working in the project ward compiled the questionnaire which asked two questions:

- What do you feel are the current barriers in relation to providing improved continence care?
- What would you find beneficial to learn from a continence study day?

Thirty questionnaires were sent out and there was a 60% response rate. Nurses identified the following barriers to improving continence care:

- differences in current practice
- pads being offered as a matter of course
- lack of knowledge regarding causes of incontinence
- the assessment process, or lack of a mechanism to ensure accurate transmission of information

Staff requested education about the normal bladder function, causes of incontinence and continence promotion strategies.

### Multidisciplinary focus group

This was convened in order to reflect on current practice and agree a consensus on the way forward. Members of the focus group were as follows; a clinical skills facilitator, a lecturer-practitioner, a clinical nurse specialist, a ward manager, a staff nurse working in the project ward, an occupational therapist and a physiotherapist. All of these staff were members of the clinical governance group. The discussion focused around the responses given by nurses in the project ward to the initial questionnaire. Members of the group identified and discussed the barriers to continence assessment and acknowledged that there was an inherent lack of knowledge regarding the continence assessment process. Four themes emerged as a result of the discussion.

#### Identification of urinary incontinence/lack of knowledge of staff

Nurses do not know how to take a history or how to ask patients about symptoms that may affect those who are incontinent of urine, such as frequent visits to the toilet (frequency) or getting up at night frequently to pass urine (nocturia). There is a lack of focus on this aspect of care.

Because nurses are only ever asked whether patients are continent or not during case conferences, they never feel the need to have an in depth knowledge of the assessment process.

#### Lack of assessment documentation

The frequency volume chart has been used as a two hour toileting chart and not to assess current bladder function. Currently there is no assessment form where information pertaining to the continence assessment process can be documented.

#### Team roles in continence assessment

The continence assessment process can be shared by multidisciplinary team who are willing to become involved. Continence is not just a nursing problem.

#### Practice issues

Patients were being commenced on a trial of medication without a diagnosis of type of bladder dysfunction being established.

### Study day

A study day was held in February 2005 at Liberton Hospital to which all the nursing staff from the pilot ward were invited. Nine staff attended. The programme was developed using the information that staff had provided about their educational requirements in the staff questionnaire.

During the morning, the anatomy and physiology of the normal bladder was revised; information was given on causes of incontinence and components of a continence assessment; examples of completed frequency volume charts were analysed in small groups; role play was also used to enable nurses to understand the relevance of asking patients about their symptoms as a tool to identify type of bladder dysfunction.

In the afternoon a change management facilitator attended. Participants were involved in a discussion about the drivers and resisters to change in order to identify barriers to change and simple changes in practice participants felt could realistically be achieved.

At the end of the day an evaluation form was completed to identify the support nurses needed in order to make changes to current practice. As a result of the afternoon discussion and the course evaluations the following support was requested:

- Attendance by the clinical skills facilitator at multidisciplinary meetings
- Discussion of the project with ward manager and deputy ward manager
- Introduction of documentation and education
- The provision of measuring jugs

In service training following a similar format was also provided for 30 physiotherapists and occupational therapists.

### Facilitation

The clinical skills facilitator played a key role in supporting practitioners to make changes in their practice to improve continence assessment. This involved both practical activities to make things easier for staff and working alongside practitioners to help them to understand what needed to be changed and to explore ways in which this could be achieved. Examples of the approaches used are outlined below.

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As further educational needs were identified, ward based education sessions were provided. These included the use of frequency volume charts and the assessment of post void residual urine volume using a portable bladder scanner.

The clinical skills facilitator also attended six multidisciplinary team meetings to facilitate focused discussions on the continence assessment process, and review complex presentations. The benefits of using this approach were threefold. Firstly, to facilitate discussion on continence care at multidisciplinary team meetings; secondly to review the success of strategies that had been put in place; thirdly to equip nursing staff with the necessary knowledge and skills required to assess patients with urinary incontinence.

An open line of communication between the clinical skills facilitator and staff in the project ward meant that feedback could be given to staff on the appropriateness of actions taken in the continence assessment process or management strategies that had been instituted could be reviewed. For example, one nurse had appropriately questioned medical staff who had prescribed a treatment for a patient that was contraindicated. The clinical skills facilitator could give positive feedback about the appropriateness of this response.

Tools to support change were also introduced. For example, a continence assessment checklist was placed within an established multi-disciplinary team sheet used at the case conferences. This was a good example of the clinical governance team responding to views of the consultant geriatrician and nursing staff. By incorporating the checklist into the multidisciplinary team sheet continence assessment became and integrated part of the bigger assessment process.

A 'continence wheel' developed by The Continence Foundation (2005) was obtained for each member of the multidisciplinary team working in the pilot ward. This is a resource that give details about presenting symptoms, potential causes of incontinence and links this to the type of bladder dysfunction.

## Evaluation

A semi structured questionnaire was developed and sent to nurses in the pilot ward. The questionnaire was completed by two nurses and two occupational therapists. Their responses were used to inform a focus group discussion that was held in December 2005. The focus group consisted of the clinical skills facilitator, a lecturer practitioner, the head occupational therapist, a clinical nurse specialist, and the two nurses and two occupational therapists from the pilot ward who had completed the questionnaire.

Four evaluation themes arose out of the focus group discussions.

### Communication

This theme related to communication with patients, the ward based multidisciplinary team and community nursing staff. For example:

- I now 'think' about continence as an important aspect of my patient care
- Continence and management of incontinence with patients is now discussed at an earlier stage and in a structured way using the checklist
- I ask more questions about the 'bigger picture of

incontinence' for example, how long have you had this problem? How does it affect your life? How do you manage it ?

- I understand that involving the patient in discussions about this aspect of care helps them to understand what can be done and will positively affect their level of compliance
- We now have increased contact with the community nursing team to ensure continuity of care on discharge
- Before being involved in this project patient discharge was viewed more as an end result for us, now we realise it is part of a continuum of care
- We are now aware that there are problems with the supply and delivery of incontinence products in the community and that it is vital that communication is established with the community staff at an earlier stage prior to the discharge

### Team approach

This theme related to the role of the multidisciplinary team in improving continence assessment. For example:

- At the multidisciplinary team meetings there are more focused discussions about continence assessment, diagnosis and the management approach
- The team meetings became a valuable learning opportunity for the nursing staff. Nurses and allied health professionals felt able to ask questions in a 'safe learning environment'
- It is clearer to each member of the team what their role is in relation to continence and their contribution. For example, the occupational therapist contributes to the assessment and management of the functional element of care. It is no longer viewed as the just the 'nurses job'

### Motivation

This theme related to factors that motivated staff to change practice. For example:

- Having a continence 'champion' to motivate and keep the momentum going was a key to its success
- We had a 'champion' on our ward who made us feel that we could make a difference
- Having the expertise and people motivated about continence care created a culture of learning. This was reinforced by the clinical skills facilitator, clinical nurse specialist, members of the multidisciplinary team and the consultant

### Education

This theme related to the education and training that had been provided. For example:

- Having a reasonable number attending the study days helped to the success of creating a learning culture in the clinical area and enabling improvements in care
- The new knowledge facilitated nursing staff to make informed decisions about not only continence management but also catheter management
- One nurse stated that both her knowledge base and her attitude had changed towards continence assessment: 'it was quite an experience to learn all this after 27 years of nursing'
- The approach to the study days was a key element to the success of this project namely the use of role-play, learning how to utilise and analyse the frequency volume charts and the 'change management' sessions were all of particular benefit
- There is more willingness to share our new learning and knowledge base with others, for example, student nurses, student allied health professionals and health

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care assistants. This reinforced to us that our competence and confidence about continence care had improved

The focus group evaluation demonstrated that significant and tangible improvements had been made towards continence management and positively influenced patient outcomes. The participants all recognised and indeed mentioned in the focus group meeting that the communication process between nurse and patient could be severely restricted in a patient who was confused or cognitively impaired. This could have a negative impact on the continence assessment process and limit successful introduction of any treatment or management strategies.

Written feedback was obtained from the consultant geriatrician who stated that the project had been significant. He stated that continence assessment had become a high priority with assessments commenced earlier and symptoms being discussed in language patients could understand. He recognised tools such as frequency volume charts, urinalysis and bladder scanning were used.

These findings will be evaluated through an audit that will be performed in Liberton Hospital comparing the pilot ward with another medicine of the elderly ward.

## Conclusion

This project was driven by the need to improve the continence assessment process within the medicine of the elderly directorate. The desire to introduce a change in practice was reflected by the enthusiasm and commitment of all those involved in the pilot programme. An umbrella approach was taken to include as many team members as possible. The qualitative data obtained from the focus group discussions provided valuable information both on the barriers to continence assessment occurring, and the positive impact of the interventions provided. Whilst there is evidence that a change in practice has occurred, sustainability of this intervention may well be dependent on the factors that led to its success i.e. continuity, facilitation, communication.

## Limitations

Limitations of the project were acknowledged. There was a small number of staff feeding back at the evaluation focus group, the project concerned patients and staff in one ward and there was difficulty finding an objective measure to evaluate the impact of the intervention on patient care. These will be addressed as the project continues to develop.

## Recommendations for implementing change

- To have a core membership of staff (implementers and participants) who will remain involved throughout a project to ensure continuity
- To involve staff from one ward rather than one member of staff from a number of different wards in a change management programme
- To have open and ongoing communication between all disciplines in the implementation group and the ward where change is planned
- To have ongoing facilitation to support the education and change management programme
- To have a continence 'champion' already working within the ward where change is planned

## Future Plans

The next stage of the project is to perform a comparative audit (between the pilot ward and another medicine of the

elderly ward) using an audit tool based on the Scottish Intercollegiate Network Guideline (SIGN, 2004). The audit data will then be used to adapt and inform future training programmes. The clinical governance group (with an increased membership) will be meeting to review the project and discuss how the pilot programme can be rolled out to other wards within medicine of the elderly.

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