National Audit of Continence Care

Combined Organisational and Clinical Report

September 2010

Commissioned by:
The Healthcare Quality Improvement Partnership

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Foreword

The National Audit of Continence Care 2009 provides the largest, most detailed evaluation of continence care in Europe. This latest round demonstrates that, although the amount of authoritative guidance is increasing, the quality of continence care remains variable and in some respects remains poor. We hope this report will arm you with the information on which to base changes and improvements in your local services where they are necessary.

For some of you, this is the first round of National Audit dealing with this highly prevalent but often neglected condition. For others, this is the third round. In the last four years much has altered; the National Health Service in England and Wales has continued to see a period of profound organisational change. The National Institute for Health and Clinical Effectiveness has published its guidelines in Urinary Incontinence in women (CG40)[1], Faecal incontinence (CG49)[2] and has recently published guidelines on Lower Urinary Tract Symptoms in men (CG97)[3]. There is certainly plenty of guidance about, but there are clear deficits in implementation[4]

The purpose of this audit was to enable those involved in managing continence, whether commissioners or providers of services and care to individuals, to compare their performance to evidence based quality standards and against other audit participants. This allows variations in the standards of care and delivery to be highlighted and should lead to improvement in the standard of care provided. Sites in previous rounds will only have their results for the current round shown in this report. To be able to compare their own performance over time with 'others' they need to extract their previous data from their earlier report(s).

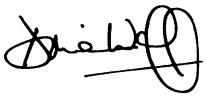
An executive summary report will be sent to Chief Executives of Trusts, PCTs, care home providers, Strategic Health Authorities, Local Health Boards, the Department of Health, the Care Quality Commission, Members of Parliament with a known interest and continence charities as appropriate. Presentations at national and international level and peer-reviewed papers will be produced in due course. To achieve change in the management of continence care the efforts of many people within health and social care are required. Please circulate this report as widely as possible and take appropriate action in areas where your centre is performing poorly against others.

Data concerning your participation in the audit will be returned to HQIP and individually identifiable data will, for the first time, be available in the public domain. We think that this is a step forward in encouraging a positive change for people with continence problems. These data are identified throughout this report and are OUTLINED IN BOLD AND SHADED GREY**.**

We shall, in addition, produce a master slide set into which you can import your site specific data for local use. By maximising the impact of the audit we hope to keep the issue of continence care in the forefront of people's minds and on the political agenda.

We are interested in receiving feedback to this report, so please use the HQIP network site if you want to comment on your results, your experience of the audit and any lessons you have learned from it. We will share specific examples of good practice as much as we can.

We recognise that this audit has involved many individuals spending time over and above an already heavy workload with no financial recompense and are grateful for the personal commitment required to make this audit worthwhile. We very much hope that everyone will gain useful information from this project and hope that you agree that this is a significant step in raising the profile of continence and improving quality of care of people with bladder and bowel problems.



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Executive Summary

The first National Audit of Continence Care for Older People, sponsored by the Healthcare Commission, was published in November 2005. The results from that audit generated much interest and harnessed an impetus for change. This report presents the results from the 3rd round of the organisational and clinical National Audit of Continence Care which examined the structure and provision of care for people with lower urinary tract symptoms and incontinence, and faecal incontinence in primary care, secondary care and care homes in England, Wales and Northern Ireland, and compared this to current national guidelines. Well organised services, based upon national guidelines have been shown to deliver higher quality care to patients. As judged by the national guidelines however, this round of audit shows there is still considerable variation in both the organisation of services and the way they deliver care to patients.

Headline findings:

ORGANISATIONAL AUDIT
The great majority of continence services are poorly integrated across acute, medical, surgical, primary, care home and community settings, resulting in disjointed care for patients and carers.

The way continence services are presently commissioned means that:

- **those providing the care are not included in the process of commissioning**
- **many services are not set up to provide joined-up care across health care boundaries**
- **most lack a designated lead whose responsibility it is to organise, develop and improve the delivery of continence care to patients**
- **users almost never contribute to service planning or evaluation**

Provision of training for health care workers to manage bladder and bowel problems is patchy across the nation, and overall occurs in less than 50% of acute hospitals.

CLINICAL AUDIT
These gaps in organisational standards for continence care lead to gaps in clinical care. Overall, adherence to national guidance (NICE) for urinary and faecal incontinence is very variable.

Healthcare professionals are not consistently:

- **asking about incontinence in people who are at risk of the condition (e.g. older people)**
- **providing assessment, diagnosis and follow-through according to standard practice**
- **communicating information about causes and treatments of patients' incontinence**
- **asking patients about their *own* goals for treatment**
- **assessing the impact of incontinence on quality of life**
- **making care plans to achieve treatment goals and sharing these with patients and (where relevant) carers**

Quality of care (assessment, diagnosis and treatment) is worse in older people (patients aged 65 years and over as compared with those aged <65).

OVERALL FINDINGS
People of all ages, and vulnerable groups in particular (frail older people, younger people with learning disability) continue to suffer unnecessarily and often in silence, with a 'life sentence' of bladder and/or bowel incontinence.

Specific Findings:

[1] Case-finding and coding

This was not an easy exercise for sites to conduct; continence problems are seldom coded, whether in primary or acute care, unless a surgical procedure was performed. This demonstrates that continence is never high on the agenda for improvement, and the lack of coding and recognition mean that it remains hidden.

Recommendation

All **healthcare professionals** should ensure that bladder and bowel problems are accurately coded in clinical record systems. This should allow identification of the true extent of these common problems.

[2] Integrated services

Although 55-80% of services report themselves as integrated across healthcare settings, only 4 services across the country fulfil all of the requirements set out in "Good Practice in Continence Services (2000)' (see DH website) and reiterated in the National Service Framework for Older People (*Table 23, organisational).* Published data suggest that those services which comply with the recommendations provide higher quality care.[1]

The goal of integrated continence services for all adults, for which there is evidence for effect[4], remains a distant one.

Recommendation

A considerable amount of organisational change is still required to meet the target of integrated continence services.

Chief Executives should ensure that continence services for which they have responsibility are part of an integrated service for their area.

Commissioning organisations and GP consortia need to involve providers in co-operative contracting to ensure continence services are provided in an integrated fashion.

[3] Commissioning

The majority (74%) of continence services in the acute sector are commissioned either via a block contract for activity or within either urology or gynaecology services The treatment pathways for continence services requires a partnership approach to the delivery of care. The commissioning of these services by block contract within general urology or gynaecology services suggests this approach is lacking (*Table 5 org report*). There is little evidence of users being involved in planning or evaluation of services.

Recommendation

Commissioners of services and GP consortia must aim for multi-provider agreements across the pathway of care, and invites for tender need to reflect this.

Users should be involved in service planning and evaluation.

[4] Designated Continence Leads

In each service there should be a Director of Continence Services or designated lead with responsibility for organisational change towards an integrated service. In acute hospitals, only 48% of self-reported integrated services have a designated lead or director. In primary care, 40% of services meet this standard (*Table 23, organisational).*

Recommendation

Commissioners need to ensure that provision, across provider units, with the relevant skilled staff is available to their population. This will ensure the implementation of NICE guidelines for care.

Chief Executives should ensure that continence services for which they have responsibility have a designated lead with responsibility as described in "Good Practice in Continence Services".

[5] Training
In hospitals, mental health care and care homes, staff with the requisite skills to perform a continence assessment are not always available to do so *(Table 29, organisational)* despite sites reporting that such staff are available *(Table 22, organisational).* Structured training in continence care only occurs in 49% of acute hospitals and 39% of mental health care sites *(Table 2, organisational)*.

Recommendation
The provision of a basic assessment; history, basic examination, provisional diagnosis and the know how to proceed should be known to all staff dealing with incontinent individuals.
Structured training and mentorship in care for people with continence should be made available to all healthcare professionals working with people who may experience problems.

Chief Executives should ensure that all staff are trained appropriately in the management of continence problems and that staff with the requisite skills are available for patients at all times. They should assure themselves that appropriate training courses are accessible and that structured training is taken up by their staff.

[6] Provision of pads and products
The majority of policies regarding the provision of containment products include a statement that provision is according to clinical need *(Table 37, organisational)*. However 66% of primary care sites impose a limit on provision *(Table 40, organisational)*.

Recommendation
Patients must be given choice on type and amount of containment products.
Single contractual arrangements should be implemented where there is a limited range of containment products.

[7] Privacy and Dignity
Despite much attention to the privacy and dignity agenda, and high overall satisfaction with facilities, the environments in which continence assessments and consultations are conducted remains of concern to some *(Table 31, organisational)*.

Recommendation
Chief Executives should ensure that the environment where assessments for continence care are carried out are fit for purpose, affording privacy and dignity to patients in all settings.

[8] Clinical Assessment
Significantly fewer older than younger people in acute and primary care settings either have a continence history *(Table 6, bladder)* or focused examination *(Table 19, bladder)* taken. This is at odds with the known prevalence of incontinence in older people. It is well documented that people with incontinence are often too embarrassed to come forward and seek help for the symptom.

Recommendation
Healthcare professionals (in acute hospitals, primary care, care homes, and mental health settings) should routinely ask a **case finding question** about bladder or bowel incontinence whenever they encounter older people and other at risk groups (individuals with learning disability, neurological conditions, immobility).
An assessment should be routinely offered should there be a positive response. Case-finding triggering assessment is a simple quality indicator that should be recorded.

Many people appear to have unnecessary investigations associated with their initial assessment for bladder problems. The need for these should be reviewed in the light of relevant NICE guidelines *(Table 22, bladder).*

Recommendation
All continence services should review or introduce assessment protocols which are in accordance with current evidence and guidelines.

The recording bowel of histories was sub-optimal, particularly in the older age group.

Recommendation
All patients who indicate that they have a bowel problem should receive an assessment that includes: *(Tables 63-69, bowel)*
- Frequency of faecal incontinence (FI)
- Bowel history (duration, pattern, stool chart)
- Impact on quality of life
- Digital rectal examination (DRE)

The role of the DRE in continence assessment has been reinforced by national guidelines. Despite this, the proportion of patients undergoing a DRE for urinary incontinence remains low. For assessment of faecal incontinence, this examination is essential yet only 53% of older people in acute care, 29% in primary care, 19% in mental health care and 15% in care homes undergo a rectal examination as part of their assessment *(Table 70, bowel).*

Recommendation:
All patients with bladder and/or bowel continence should have a DRE (with their consent) as a basic part of assessment.
Healthcare professionals should ensure that they are competent to perform DRE.
Those responsible for services should ensure that there are practitioners who are appropriately skilled to perform the examination and that training is provided to all non-specialist clinicians engaged in assessment of patients with urinary and faecal incontinence.

Cause(s) (often multiple) for faecal incontinence are generally not clearly identified, which clearly leads to poor treatment and care. Where causes are identified, faecal impaction, anorectal disease, diarrhoea, neurological disease and contributing causes of comorbidity, reduced mobility, cognition, and medications are most common.

Recommendation:
Healthcare professionals should ensure that both condition-specific causes, and contributing causes for faecal incontinence are clearly identified and appropriately managed.

[9] Quality of Life measures
Bladder symptoms and faecal incontinence can have a very negative impact on quality of life. Quality of life is rarely taken into account when an assessment of continence is performed despite NICE guideline recommendations *(Tables 12-14, bladder and Table 67, bowel).* Quality of life is particularly poorly documented in older people.

Recommendation
Continence services should ensure that standardised validated measures of quality of life (as recommended in NICE guidance) should always be included in continence assessment and review of treatment effects.

[10] Treatment
Care plans are poorly documented for patients with faecal incontinence, and for patients with urinary incontinence in acute and mental health facilities, which is likely to impact effective treatment. Rates of some bladder treatments are lower than may be expected (alpha blockers and antimuscarinincs in men, surgery for stress incontinence in women). Treatment plans, lifestyle and dietary advice and referrals for specialist care are all more commonly reported in younger than older people.

Recommendation:
Treatments for lower urinary tract symptoms, urinary incontinence in women, and faecal incontinence should be offered to all patients as per existing national guidance.
Cure rather than containment should be the principle aim of treatment.
Healthcare professionals should fully discuss treatment options with patients.
Local audit cycles should be used to push up standards and adherence to national guidance.

[11] Communications with users
Communication with patients (and carers where relevant) about the causes and management of their faecal incontinence is poorly documented, and few receive copies of their care plans *(Table 83, bowel).* Provision of patient support, in the form of literature is reported as being widely available *(Table 41, organisational)* but further communication beyond handing out of a leaflet is rarely documented. Lack of documented patient goals for treatment probably does not fully reflect actual practice, but on balance of probability, there is still much room for improvement.

Recommendation:
Healthcare professionals should discuss causes and treatment options with patients (and carers where relevant) in such a way that patients own goals for treatment are identified and recorded.
Healthcare professionals should ensure that there is a shared treatment plan that is regularly reviewed to achieve treatment and care goals.

[12] Older versus younger patients
Across the board older patients (aged 65 years and above) are less likely to have evidence-based assessment and management, and communications with older people (particularly in acute setting) is poor. Comparison with previous national audits for older people show that whilst there has been some improvement in providing continence services for them, there remains a strong imperative to involve patients more in their own care.

Recommendation:
Healthcare professionals should be aware of inequitable continence care with respect to older people
All patients with incontinence should have evidence-based and patient-centred care, regardless of their age.

Conclusion

There is an urgent need for improved and equitable practice for all people with bladder and bowel problems.

Further work must be done to achieve an acceptable standard of care for the many thousands of individuals with incontinence, by developing:

- **commissioning frameworks**
- **training health professionals with regard to national evidence based guidelines**
- **empowering patients to increase their expectations of cure.**

Aims of the organisational audit

1. Improve care for people with continence problems as highlighted in *Good Practice in Continence Services* (DH, 2000).
2. Demonstrate variation in available services relating to the management of continence problems in older people across different healthcare settings.
3. Enable healthcare settings (in primary care, secondary care (including mental health care) and care homes) to compare the quality of their continence care to evidence based criteria
4. Monitor the NSF for Older People milestone for establishing integrated continence services (April 2004).

Method

Throughout this report, distinction between the various sources of data is made as follows:

- The term 'Secondary care' is used to cover the hospital and mental health care sectors.
- Data from commissioners is derived from PCTS both from those who have split their provider arms, and those who have not.
- 'Acute Hospital' refers to data collected from acute and specialist trusts.
- Mental Health trusts are also referred to separately.

Continence audit package

The *Organisational* audit tool consisted of one e-form per site assessing the quality of care provided by the organisation, including staffing. Sites were also asked to comment where answers were not clear or did not fit their intended response well.

The web audit tool was accessible via the internet (using Internet Explorer v5.0 or above for Windows 98 and later versions) and was hosted on the Royal College of Physicians' website. All data submitted to the audit were anonymous and access to the web-tool was password-protected for confidentiality. Each site was allocated a unique site code by which they were identified and each case entered was automatically allocated a unique audit number. Help buttons were provided online next to questions and an extensive help booklet was also issued to participants.

Data Collection

The data collection proforma was updated from the previous National Audit of Continence Care for Older People. To reflect the changes in primary care commissioning in England, a short commissioning proforma was written following consultation with a continence service commissioner. The final decisions on the questions were taken by the Continence Care Audit Steering Group.

Each site had to complete:

- One organisational form.
- One Commissioning form was requested from all primary care organisations with this function.

Recruitment of Sites

Trusts

All NHS trusts in England, Wales and Northern Ireland were potentially eligible to take part in the audit. Some Trusts were later excluded as they were specialist trusts or children's trusts

- Information letters inviting expressions of interest were sent out to Chief Executives and Audit departments of eligible trusts.
- An online form was also made available so that trusts could register their interest in participating in the audit.
- Once sites signed up to participate they were required to fill in a more comprehensive registration form with their full and correct contact details to facilitate communication.
- Organisations were then asked to choose a site (or sites) from within their trust to collect the data.

Care Homes

The aim was to encourage as many independent care home providers to become involved with the audit.

- The project team held meetings with Independent Care Home Providers in the hope of encouraging them to participate in the audit.
- Anchor Trust, BUPA, Barchester, Southern Cross Healthcare and Four Seasons were contacted.
- Anchor Trust and Southern Cross Healthcare provided the details of a sample of their care homes and from this those willing to participate were identified.
- Barchester Care Homes decided that they wanted the whole of their nation wide group of care homes to participate and included this audit in their own in-house focus and training on continence.

General

Once the participants full contact details were established (both trusts and care homes) they were assigned Site ID and Passwords for each site. These would give them access to the continence audit web site which contained the proformas, help notes and other materials

The process was not always an easy one; the demands and pressures on organisations and audit departments have increased greatly since the previous round of data collection.

Presentation of results

The statistical summary of results is organised by 4 sectors, with results for your site in the last column. Data are expressed in percentage and absolute terms and where data were not applicable the denominator is adjusted accordingly. The audit designated a-priori specified circumstances where measures did not apply – for example if someone has problems of mental incapacity or there is documentary evidence that a particular procedure was not performed as it was too distressing to the patient.

The electronic input method guaranteed that missing data levels (i.e. 'blank' entries) were again very low and it was made clear in documentation that any missing data would be regarded in the negative for the measures in the audit.

Data quality & anonymity
No identifiable data left care facilities. The use of anonymised data for central input meets the requirements of confidentiality and data protection legislation.

Non-participation
Reasons for not taking part in the audit included lack of resources, time pressures or the confusion over the split between commissioners and providers.

ORGANISATIONAL

& COMMISSIONING AUDIT

FULL NATIONAL RESULTS

Organisational and Commissioning audit

Participation Numbers:

Table 1: Trust Participation

Region	Type of TRUSTS	Trusts Eligible to Participate 2009	Trusts registered 2009 (% of those eligible)	Trusts participating 2009 (% of those eligible)	Sites participating 2009	2006 Audit Participation of Trusts
England	Acute	161	143 (89%)	135 (84%)	150	83%
	Primary Care	144	96 (67%)	86 (60%) Including:36 both organisation & commissioning	97	43%
	Mental Health	57	35 (61%)	26 (46%)	31	45%
Wales	Combined	7	6 (86%)	6 (86%)	12	69%
Northern Ireland	Combined	5	3 (60%)	3 (60%)	5	44%
Islands	Combined	2	2 (100%)	2 (100%)	3	67%

Some sites withdrew during the organisational audit process.

Acute Trusts which comprise more than one hospital audited several sites. Each site is identified separately in the audit. Although it was recommended that primary care entered GP practices into the audit, some audited their hospital sites, some entered their hospital sites. For the organisational audit; this made no difference to the analysis

Others which have not completed the organisational audit are still willing to complete the clinical audit.

Primary care sites which identified that they had a commissioning function completed the relevant proforma. Joint commissioners and providers of services in primary care variably returned commissioning proformas.

For the purposes of analysis by sector the combined trusts of Wales. Northern Ireland and the Islands were merged in with the Primary Care Trusts of England to form the Primary Care sector with 117 sites in the national analysis.

Care Homes:

Table 2: Care Home participation

	Registered	Participated (% of those registered)
Barchester	200	120 (60%)
Anchor Trust	13	2 (15%)
Care Homes Overall	213	122 (57%)

Care homes found the audit very difficult. Some did not have the facilities to provide the required information and others found the content complicated to answer.

Results: Commissioning

43 PCTs submitted commissioning data, 36 of whom also responded to the organisational audit. The response rate is unknown as the total number of eligible commissioning PCTs is unknown. This reflects the current state of flux within primary care and the relationships between provider and commissioning arms in England. In Wales, local health boards, whilst reducing in number, continue to both commission and provide services.

Your site DID NOT submit commissioning data

Good practice in continence services The DH publication "Good practice in Continence Services" (2000) sets out guidelines for the establishment of integrated continence services, standards for delivery and audit

Table 3: Commissioning

	Primary Care	
	%	N
1.1 Are you aware of the Department of Health guidelines for good practice in continence services?	95	41/43

Some commissioners were unaware of the guidelines as there had been no recent commissioning of these services. For one organisation, a redesign was planned for 2010.

Table 4: Commissioning

	Primary Care	
	%	N
1.2i Do you ensure that the service you commission includes: Director of Continence services or head of services with responsibility for policy?	84	36/43
1.2ii Do you ensure that the service you commission includes: Clear referral pathways for patients between Providers?	95	41/43

The response to question 1.2 should be viewed in light of the response to question 3.1i in the organisational questionnaire (Table 23); and perhaps suggests that our sample was biased towards the more proactive commissioners of services and which is borne out by the crosstabulation of data (not shown).

Table 5: Commissioning

	Primary Care	
	%	N
1.3 Do you currently commission according to NICE guidelines and the accompanying toolkits for this purpose?	74	32/43

Reasons given for not doing so included staff shortage, with the focus being on delivering the 18-week targets; lack of resource and plans to do so in a current redesign process.

Table 6: Commissioning

	Primary Care %	Primary Care N
1.4 Who provides community continence services (continence advisory service) within your area?		
• GP	28	12/43
• Acute Trust	26	11/43
• Private provider of NHS services	12	5/43
• Alternative provider organisation	9	4/43
• Social enterprise	5	2/43
• Primary care provider	93	40/43
• Other*	5	2/43

*Other respondents named service providers with an unclear provenance.

Table 7: Commissioning

	Primary Care %	Primary Care N
1.5 How are hospital continence services commissioned?		
• As for Community Service	21	9/43
• Block Contract for activity	26	11/43
• Within existing Urology/urogynaecology services	49	21/43
• Other	5	2/43

Most commissioning of continence services appears to be either by block contract or as a community service. In acute trusts, services exist either within Urogynaecology, Gynaecology or Urology and are not specifically commissioned.

Table 8: Commissioning

	Primary Care %	Primary Care N
1.6 Do you have any existing non- financial performance indicators for quality in continence care for the services you commission?	44	19/43

Approximately half of the commissioning organisations replied yes to this question. Some mentioned participation in this audit as an indicator. The majority mentioned the use of patient surveys to measure patient experience or satisfaction. Others mentioned treatment outcome, presence of care planning. Few responses were specific to continence and measured process through the system. Only 2 services mentioned CQUIN.

Table 9: Commissioning

	Primary Care %	Primary Care N
1.7 Do you currently use (CQUINS) Commissioning for Higher Quality and Innovation as part of your performance management criteria for these services?	30	13/43

See results in relation to Table 8. There is a clear difference in response to these two questions. The reason for this is unclear.

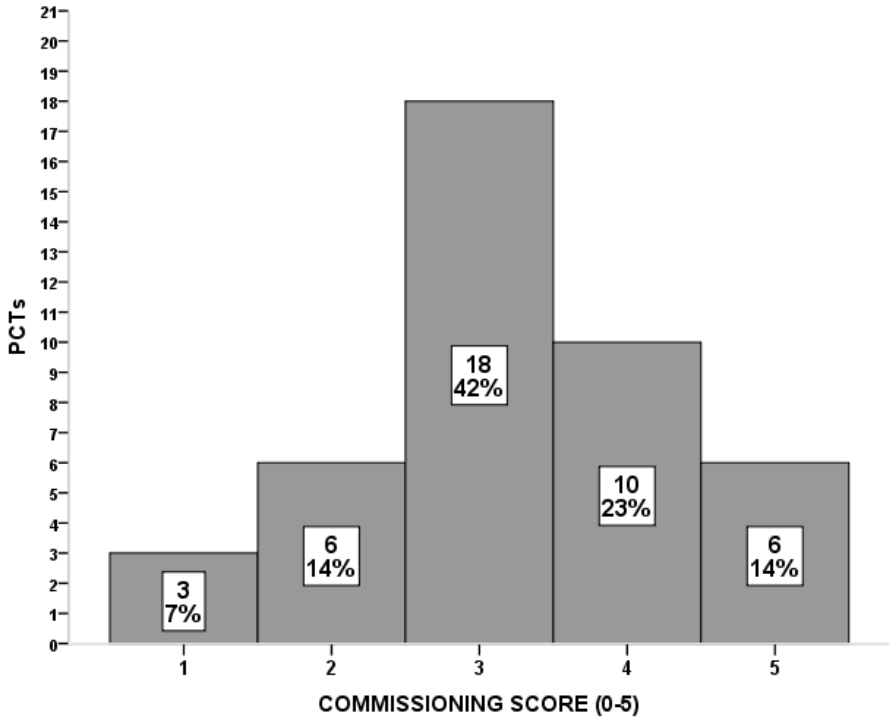
Commissioning Score (Range 0-5)

A commissioning "quality score was derived using a consensus method (See methods). Five items were scored as either 1 or 0 to give a total commissioning score for continence services from 0 to 5. The questions used and the scores/weights used are given below, with the results shown in Table 10:

Scoring system: Commissioning score for Continence Services		Scoring
1.1	Are you aware of the Department of Health guidelines for good practice in continence services?	YES=1 NO=0
1.2 1.2i 1.2ii	Do you ensure that the service which you commission includes: • Director of Continence services or head of services with responsibility for policy? • Clear referral pathways for patients between Providers?	BOTH YES = 1 EITHER NO = 0
1.3	Do you currently Commission according to NICE guidelines and the accompanying toolkits for this purpose?	YES=1 NO=0
1.6	Do you have any existing non- financial performance indicators for quality in continence care for the services you commission?	YES=1 NO=0
1.7	Do you currently use Commissioning for Higher Quality and Innovation (CQUIN) as part of your performance management criteria for these services?	YES=1 NO=0

Table 10:

COMMISSIONING SCORE FOR CONTINENCE SERVICES	Primary Care %	Primary Care N
• ZERO	-	0/43
• ONE	7	3/43
• TWO	14	6/43
• THREE	42	18/43
• FOUR	23	10/43
• FIVE	14	6/43



Your commissioning score is:

Results: Provider Services

Policies and Procedures

Each facility should address the issue of urinary and faecal incontinence and its management because of its high prevalence and to ensure standards of care.

Good practice in continence services (DH, 2000) Chapter 3, 3.4: *Continence services provided for a specific population should be organised as **integrated continence services**. The various professionals providing care at different levels will be employed by different bodies but if services are to be integrated, in line with clinical governance principles, they should all:*

- *work to common evidence based policies, procedures, guidelines and targets;*
- *use agreed evidence based policies, procedures and guidelines;*
- *undertake audit and review.*

The written policy should be more than a flow diagram for treatment. It should be a written policy concerning the management of continence care.

Table 11: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.1 Does the facility (GP practice/ hospital /care home), or the continence service covering the facility, have a written policy for the management of continence? **%YES**	41	61/150	86	101/117	52	16/31	98	120/122
If YES, does this policy include:								
1.1i Training for staff in continence care	80	49/61	89	90/101	75	12/16	97	116/120
1.1ii Assessment and treatment of incontinence	98	60/61	100	101/101	94	15/16	98	118/120
1.1iii A means for regular audit of continence services	70	43/61	76	77/101	63	10/16	75	90/120

Where policies existed, and as in the previous surveys, these are less frequently present in the acute setting, they include something about training and assessment. Less frequently is audit or quality control included.

Acceptance of direct referrals removes referral barriers in line with the recommendations in **"Good Practice in Continence Services".**

Table 12: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.2 Does the continence service to which patients have access accept self referrals? **%YES**	37	56/150	95	111/117	65	20/31	57	69/122

Despite the rise in primary care referral management centres there is still a surprisingly high proportion of hospital services which say that self-referral is accepted. Whether the current 95% level in primary care is maintained in the light of continued reform remains to be seen.

Table 13: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.3 What is the nature of the current provider of NHS continence care to which patients have access?								
Community provider	71	107/150	91	106/117	68	21/31	51	62/122
Hospitals service	73	110/150	36	42/117	65	20/31	27	33/122
Alternative provider organisation	3	4/150	7	8/117	-	0/31	2	3/122
Primary care network	21	32/150	29	34/117	23	7/31	44	54/122
Private provider of NHS services	5	7/150	7	8/117	6	2/31	9	11/122
Not known	1	1/150	-	0/117	3	1/31	6	7/122
Other*	-	0/150	-	0/117	16	5/31	4	5/122

* "Other" responses included pad delivery companies, no continence service and a variety of probable primary care organisations which were impossible to define further.

The number of alternative provider organisations and private providers remains low. Given the changing nature of healthcare provision, one might expect this proportion to rise.

Table 14: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.4 Are there local plans to change the provision of NHS services away from the current provider? **%YES**	7	11/150	8	9/117	13	4/31	2	3/122

Few organisations had any plan, to the best of the respondent's knowledge, to alter their service provider.

Table 15: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.5 Does the facility utilise an Integrated care pathway or an evidence based treatment algorithm for patients with incontinence?								
Integrated care pathway	37	56/150	62	73/117	52	16/31	34	41/122
Algorithm	44	66/150	56	66/117	13	4/31	6	7/122
Care plan	53	79/150	54	63/117	55	17/31	83	101/122
None of these	25	37/150	3	3/117	16	5/31	6	7/122

Care plans for those with incontinence are common in care homes, but the use of treatment / management algorithms is rare. This suggests post diagnosis care rather than diagnosis and management is strong in this sector.

NICE CG 40: Chapter 6. Competence of surgeons performing operative procedures for urinary incontinence in women. *Surgeons undertaking continence surgery should maintain careful audit data and submit their outcomes to national registries such as those held by British Society of Urogynaecologists (BSUG) and British Association of Urological Surgeons Section of Female and Reconstructive Urology (BAUS-SFRU).*

Table 16: Policies & Procedures

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
1.6 Does the facility submit surgical audit data to the relevant specialist society database?								
NA	16	24/150	65	76/117	87	27/31	59	72/122
NO	41	62/150	26	31/117	10	3/31	41	50/122
YES	43	64/150	9	10/117	3	1/31	-	0/122

Despite NICE guidelines, fewer than half of the sites with surgical activity submit audit data to the relevant database.

Case Finding

Good Practice in Continence Services (DH, 2000) Chapter 3, 3.8: *The early detection and treatment of incontinence requires recognition of signs and symptoms by all professional staff involved in patient care. A proactive approach in clinical consultations (including consultations with carers) will assist with identification of cases as will availability of information in GP surgeries and hospital clinics.*

There should be a means of identifying all patients with urinary and faecal incontinence e.g. a trigger question related to bladder continence as part of their general health assessment. Patients' positive response to a trigger question about urinary and/or faecal incontinence should always lead to an offer of assessment.

The Single Assessment Process for Older People (DoH, 2001) should include a case finding question. NICE CG40 and 49 also recommend a case finding question.

Older people:
The Single Assessment Process for Older People (NSF for Older People 2001) should include a screening question. For example "Do you have any problems with your bladder or bowels?" All adults NICE recommendation.

Table 17: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
2.1 Is it the facility's practice to ask a screening question relating to bladder and bowel problems as part of the initial assessment? **%YES**	96	144/150	90	105/117	87	27/31	93	113/122

Good Practice in Continence Services (DH, 2000) Chapter 3, 3.12: *All patients presenting with incontinence should be offered an initial assessment by a suitably trained professional.*
A basic assessment of continence problems is performed by a practitioner who is

- Able to take a continence history
- Able to perform a rectal examination
- Able to perform a urinalysis.

Assessment: a basic assessment should include targeted history of storage and voiding problems for both bladder and bowel, previous treatment, ability to reach the toilet for successful voiding. A rectal examination and urinalysis should be performed where possible.

Table 18: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
2.2 Is there a written protocol for providing a basic assessment for all people who indicate that they have problems with urinary and/or faecal continence? **%YES**	54	81/150	90	105/117	48	15/31	93	114/122

These data replicate the findings of the 2006 National Audit of Continence Care for Older People. Whereas it appears to be standard practice to ask a case finding question relating to bladder and bowel dysfunction of all; in acute care settings there is no accompanying directive to do anything about those who indicate that they have a problem.

Functional ability

Consensus guidelines – Royal College of Physicians (RCP): An assessment of functional ability will enable management decisions for that patient to be tailored to meet their capacity. Examples might be:

- The Barthel Index
- Functional Impairment Measure
- Minimum Data Set Resident Assessment Index (MDS-RAI)

Table 19: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
2.3 Does the facility routinely use a standardised measure to record functional ability for older patients (e.g. Barthel/MDS-RAI)? **%YES**	57	85/150	34	40/117	32	10/31	41	50/122

Cognitive function

Consensus guidelines – Royal College of Physicians (RCP): An assessment of cognitive ability will enable management decisions for that patient to be tailored to meet their capacity. Examples might be:

- Abbreviated Mental Test Score (10pt)
- Mini Mental State Examination (30pt)

Table 20: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
2.4 Does the facility routinely use a standardised measure to record mental state e.g. Abbreviated Mental Test Score, Mini-Mental State Examination)? **%YES**	74	111/150	34	40/117	97	30/31	52	63/122

Symptom severity

Assessment of symptom severity will allow comparison of treatment effect.

NICE CG 40: Chapter 3: Assessment and investigation, Symptom scoring and quality of life assessment. 3.8: Grade D, (GPP): *The following incontinence-specific quality of life scales are recommended when therapies are being evaluated: ICIQ-SF Bristol Female Lower Urinary Tract Symptoms (BFLUTS), I-QoL, SUIQQ, UISS, SEAPI-QMM, ISI and Kings Health Questionnaire (KHQ).*

Table 21: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
2.5 Does the facility routinely use a clinically defined measure of severity of symptoms? **%YES**	45	68/150	68	79/117	29	9/31	48	58/122

The use of standardised instruments to measure physical and cognitive function is appropriate for those likely to have impairment and should be in routine use. The absence of routine use of a clinically defined measure of severity of symptoms across all settings is interesting, given the increasing importance of patient reported outcome measures in this field.

Good practice in continence services (DH, 2000) Chapter 9, 9.3: *NHS trusts should ensure that there are planned programmes of education and training.* Training in continence care should be undertaken by all staff involved in the integrated service. Such training should be appropriate for the level of staff.

There should be a structured and comprehensive programme of staff training on promoting urinary continence. Training should include:

- Knowledge of the aetiology of urinary and faecal incontinence
- Experience in taking history
- Ability to carry out an abdominal, rectal and pelvic examination
- Ability to carry out residual volume measurement (urinary incontinence only).

Training basic assessment

- Locally agreed continence training programme for nursing staff.

Training Specialist assessment:

- ENB 978 – or current university equivalent level 3 course BSc or MSc module in continence care.

Table 22: Screening

	Acute (Hospital)	Primary Care	Mental Health	Care Home
2.6 Does the clinical team include a practitioner who has had training to:				
2.6i take a continence history?	Yes 90% (135/150) D:108 N:119 P:61 O:4	Yes 98% (115/117) D:24 N:114 P:40 O:7	Yes 77% (24/31) D:15 N:18 P:4 O:2	Yes 87% (106/122) D:8 N:98 P:2 O:12
2.6ii initiate a frequency-volume chart?	Yes 89% (133/150) D:78 N:127 P:50 O:7	Yes 99% (116/117) D:21 N:116 P:34 O:10	Yes 77% (24/31) D:7 N:23 P:1 O:2	Yes 80% (98/122) D:6 N:88 P:1 O:16
2.6iii perform a rectal examination?	Yes 95% (142/150) D:135 N:79 P:20 O:2	Yes 91% (106/117) D:38 N:99 P:19 O:2	Yes 81% (25/31) D:24 N:9 P:0 O:0	Yes 38% (46/122) D:28 N:28 P:1 O:1
2.6iv perform a urinalysis?	Yes 99% (149/150) D:78 N:149 P:24 O:20	Yes 99% (116/117) D:32 N:116 P:24 O:15	Yes 90% (28/31) D:15 N:28 P:0 O:6	Yes 89% (109/122) D:10 N:103 P:0 O:22

Key: D=Doctor, N=Nurse, P=Physio O=Other

As might be expected, the required skills present for care are ubiquitously present throughout the each healthcare setting although there appears to be a relative lack of clinicians able to perform rectal examinations in care homes.

Good practice in continence services (DH, 2000) Chapter 3, 3.5: *A locally provided continence service comprising:*

- *Director of continence services;*
- *Continence nurse specialists including paediatric continence nurse specialists and specialist continence physiotherapists;*
- *Designated medical and surgical specialists;*
- *Investigation and treatment facilities;*
- *National or regional units for specialist surgery.*

Lead of integrated continence service: the nominated person for developing, implementing and co-ordinating policies, procedures and protocols. The DoH guidelines suggest this would normally be a physiotherapist or nurse.

Table 23: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
3.1 Does the facility have access to an integrated continence service? (as defined by "Good Practice in continence services") (DoH 2000)	55	83/150	75	88/117	71	22/31	80	98/122
3.1i If yes, does the service have:								
• Director of integrated services	13	11/83	11	10/88	5	1/22	5	5/98
• Lead of integrated services	42	35/83	38	33/88	32	7/22	11	11/98
(Service has Director AND/OR Lead)	48	40/83	40	35/88	32	7/22	11	11/98
• Continence nurse specialists	93	77/83	99	87/88	77	17/22	98	96/98
• Specialist continence physiotherapists	73	61/83	67	59/88	27	6/22	4	4/98
• Specialist continence occupational therapists	10	8/83	3	3/88	5	1/22	4	4/98
• Unable to find information from my local service	2	2/83	-	0/88	14	3/22	1	1/98
3.1ii If yes, does this service have designated referral pathways with:								
• Gynaecology (including Urogynaecology)	87	72/83	80	70/88	50	11/22	15	15/98
• Colorectal surgery	58	48/83	35	31/88	14	3/22	8	8/98
• Urology	81	67/83	77	68/88	55	12/22	28	27/98
• Gastroenterology	39	32/83	17	15/88	18	4/22	8	8/98
• Geriatric Medicine	53	44/83	23	20/88	32	7/22	17	17/98
• Neurology	39	32/83	27	24/88	32	7/22	13	13/98
• Community continence Service	70	58/83	81	71/88	64	14/22	55	54/98
• Via GP specialist consultant	14	12/83	17	15/88	27	6/22	37	36/98
• None of the above	4	3/83	1	1/88	-	0/22	6	6/98
• Unable to find the information from my local service	2	2/83	2	2/88	23	5/22	12	12/98

The "gold standard" for continence services, a model of service integrated between primary and secondary care, with a defined lead (Director) and seamless delivery of inter-disciplinary referral remains a distant goal for the majority of services. The last organisational audit (2006) reported that 56%, 66%, 63% and 69% of hospitals, primary care organisations, mental health trusts and care homes respectively had such a service. The reasons for such a lack of development require further exploration, as do the differences in perception of each sector regarding their local service.

The post of director has seldom been recruited to; this is a problem of definition, but this notwithstanding, Fewer than half of so-called integrated services have a designated lead.

Only 4 sites (1 Acute Hospital, 2 Primary Care sites, 1 Care Home) considered themselves fully integrated in that they ticked all of the organisational boxes regarding training (4.1=YES), policy (1.1=YES and all subsections=YES), access to diagnostics (3.4=YES and all subsections=YES), referral guidelines (3.1ii=YES to all subsections) and has a lead or director (3.1=YES and 3.1i=YES to lead and/or director).

NICE CG 40: Chapter 6. Competence of surgeons performing operative procedures for urinary incontinence in women. **Grade D (GPP)** *There should be a nominated clinical lead within each surgical unit with responsibility for continence and prolapse surgery. The clinical lead should work within the context of an integrated continence service.*

Table 24: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
3.2 Do the surgeons operating on people with urinary incontinence work as part of the multidisciplinary team? **% YES**	83	124/150	56	65/117	-	-	-	-

Table 25: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
3.3 Is there a designated clinical surgical lead for continence and prolapse surgery within the unit? **% YES**	85	128/150	43	51/117	10	3/31	7	8/122

3.4. Good practice in continence services (DH, 2000) Chapter 3, 3.16: *All services should have access to specialist services. These may be provided in the same locality as the treatment facilities or have clear referral paths to other hospitals. Specialist services include:*

- *Diagnostic services such as Urodynamics including cystometry and ultrasound;*
- *Therapies such as patient specific pelvic floor exercises, bio feedback, electrotherapy and bladder retraining;*
- *Surgery for urinary incontinence such as colposuspension and for faecal incontinence such as anterior repairs of anal sphincter;*
- *Medical specialties e.g. coloproctology, neurology.*

Table 26: Screening

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
3.4 Does your local service have investigation and treatment facilities, which include access to:								
• Urodynamics	99	149/150	83	97/117	48	15/31	25	30/122
• Urinary or gastrointestinal tract imaging	99	148/150	69	81/117	52	16/31	21	26/122
• Anorectal physiology	65	97/150	50	58/117	39	12/31	11	14/122
• None of the above	-	0/150	16	19/117	26	8/31	39	47/122
• Unable to find information from local service	-	0/150	1	1/117	13	4/31	32	39/122

A significant proportion of continence services appear to lack access to specialist imaging and diagnostics, required for the provision of integrated services.

Training

Good practice in continence services (DH, 2000) Chapter 9, 9.3: *Primary Care Trusts and NHS Trusts should develop and deliver in-service programmes of education and training to reflect contemporary practice and in conjunction with Higher Education Institutes (HEIs) to ensure that the curricular content of pre- and post registration training reflects continence service policy. NHS trusts should ensure that there are planned programmes of education and training.*

Table 27: Training

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
4.1 Is there a structured programme of staff training on promoting continence for the facility? **%YES**	49	74/150	86	101/117	39	12/31	74	90/122
4.1i If yes, does the programme include basic assessment? (i.e. all of these: history taking, urinalysis, rectal examination and frequency/volume charting) %**YES**	92	68/74	96	97/101	100	12/12	72	65/90
4.1ii Does the service use any of the National Occupational Standards (Continence Care) to guide the content of its training?	64 YES 19 NO 16 NA	48/74 14/74 12/74	83 YES 9 NO 8 NA	84/101 9/101 8/101	67 YES 17 NO 17 NA	8/12 2/12 2/12	44 YES 12 NO 43 NA	40/90 11/90 39/90
4.1 iii Does the service use any of the National Occupational Standards (Continence Care) to develop work based competency packages? **%YES**	55	41/74	71	72/101	58	7/12	37	33/90

Where structured training exists, the majority of this appears to teach the requirements of basic assessment of continence problems. The lack of structured training in hospitals, and mental health trusts, given the prevalence of these problems, is of concern. The national occupational standards for continence care appear to have had some impact in primary care.

Good practice in continence services (DH, 2000) Chapter 3, 3.14: *As part of the specialist services there will be continence nurse specialist or specialist continence physiotherapists who should:*

- *Deliver individual's continence care.*

Table 28: Training

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
4.2 Do patients have access to a local continence practitioner, who is able to give advice on continence, and bladder and bowel care? **%YES**	94	141/150	100	117/117	81	25/31	92	112/122
4.2i If YES, is the practitioner:								
• Hospital based	57	81/141	25	29/117	56	14/25	19	21/112
• Community based	83	117/141	99	116/117	68	17/25	87	97/112
• Not known	-	0/141	-	0/117	-	0/25	3	3/112

The majority of specialist continence practitioners remain based in the community. There is however still a strong provision within hospitals. What isn't known is to what extent there is a collaborative approach between sectors to care for people with problems. The extent to which

those sites without specialist continence practitioners did not participate in the audit is not known, although, participation was not dependent upon the existence of such staff.

Good practice in continence services (DH, 2000) Chapter 3, 3.9: *All patients presenting with incontinence should be offered an initial assessment by a suitably trained individual. This assessment is in addition to the usual patient assessment in respect of mental health, mobility, and underlying conditions and might not be conducted at a single consultation. The key components of an initial continence assessment are:*

- *Review of the symptoms and the effect on the quality of life;*
- *Assessment of desire for treatment alternatives;*
- *Examination of the abdomen for palpable mass or bladder retention;*
- *Examination of perineum to identify prolapse and excoriation and to assess pelvic floor contractions;*
- *Rectal examination to exclude faecal impaction;*
- *Urinalysis to exclude infection;*
- *Assessment of manual dexterity;*
- *Assessment of the environment eg accessibility of toilet facilities;*
- *Use of an "activities of daily living" diary;*
- *Identification of conditions that may exacerbate incontinence, e.g. chronic cough.*

Table 29: Training

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
4.3 Is a specialist continence assessment always carried out by a practitioner with training in?								
• Knowledge of the aetiology of urinary and faecal incontinence	79	119/150	98	115/117	52	16/31	55	67/122
• Experience in taking a history	79	119/150	99	116/117	58	18/31	62	76/122
• Ability to carry out an abdominal examination	63	95/150	52	61/117	35	11/31	26	32/122
• Ability to carry out a rectal examination	65	98/150	84	98/117	42	13/31	23	28/122
• Ability to carry out a vaginal examination	64	96/150	80	94/117	29	9/31	16	20/122
• Ability to perform urinalysis	79	118/150	99	116/117	58	18/31	66	80/122
• Ability to carry out residual volume measurement	75	113/150	97	114/117	29	9/31	35	43/122
• None of the above	6	9/150	-	0/117	6	2/31	8	10/122
• Not known	13	20/150	1	1/117	29	9/31	23	28/122

Within the acute and primary care setting 20% report specialist assessments being conducted by providers without basic training (i.e. knowledge of aetiology of incontinence and experience in taking a history). The provision of care within the care home sector appears to be lacking, despite data from Table 22 suggesting that these skills are possessed by clinicians within the service. Clearly some elements, e.g: residual volume measurement, are not applicable to all patients and the ability to perform this may not be required but these data give the impression that continence assessment may be performed by practitioners who do not possess the training necessary for the job.

Provision of specialist continence care by a trained member of the nursing profession is in line with the NSF for Older People (DoH, 2001).

Good practice in continence services (DH, 2000) Chapter 3, 3.9: *All patients presenting with incontinence should be offered an initial assessment by a suitably trained individual.*

Good practice in continence services (DH, 2000) Chapter 3, 3.14: *As part of the specialist services there will be continence nurse specialist or specialist continence physiotherapists.*

Good practice in continence services (DH, 2000) Chapter 5, 5.5: Indicators relating to training and continuous support. Number of whole time equivalent (WTE) of continence specialist nurse or specialist continence physiotherapists per 100,000 HA/PCG population. Return the number of WTE Continence Specialists either:

- working within the **secondary care** institution or
- per 100,000 **PCT** population
- For **care homes** these data should be available from your local continence service.

These may be either from physiotherapy, occupational therapy or nursing staff with a particular remit for continence care providing a specific service available to your care sector. This does not include district nurses, ward nurses or practice nurses who might have some role in continence care.

Table 30: Training

4.4 What is the number of whole time equivalent (WTE) continence practitioners available to you?	**Acute (Hospital)**		**Primary Care**		**Mental Health**		**Care Home**	
PCT WTE known	51%	77/150	97%	114/117	16%	5/31	23%	28/122
PCT WTE >0	96%	74/77	96%	110/114	40%	2/5	96%	27/28
PCT WTE	Median 2.3	IQR 1.0-3.0	Median 2.9	IQR 2.0-4.5	Median 0.0		Median 1.0	IQR 1.0-2.0
Hospital Service WTE known	81%	122/150	53%	62/117	19%	6/31	10%	12/122
Hospital Service WTE >0	61%	74/122	47%	29/62	67%	4/6	50%	6/12
Hospital Service WTE	Median 0.9	IQR 0.0-1.6	Median 0.0	IQR 0.0-1.0	Median 1.0		Median 0.5	IQR 0.0-1.0

The provision of continence practitioners appears to be split equally across hospital and community based services. Any comparison with the previous audit in 2006 is difficult to make because of the considerable organisational change since the audit but overall, the situation appears stable with a shift towards community practitioners working within hospitals. Whether this provision is adequate, given the prevalence and need of the population, remains to be seen.

Environment

All assessment and care is given in areas, which are private and promote dignity. The environment in which case is delivered should be sensitive to the needs of the person (Essence of Care, 2001).

Privacy – freedom from intrusion.
Dignity – being worthy of respect.
The following are of particular importance to users of services:

- Having treatment or assessment in a private room.
- Having warm, clean and separate male and female toilets.
- Having disposable pad facilities in toilets.

Table 31: Environment

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
5.1 Do the areas for both assessment AND treatment of patients with bladder and bowel problems preserve the patient's privacy and dignity according to current standards? **%YES**	86	129/150	90	105/117	94	29/31	100	122/122
5.1ii If you have ticked Yes, which of the following does this include:								
• Privacy around the bed area	97	125/129	83	87/105	97	28/29	97	118/122
• Privacy around the toilet area	98	127/129	90	95/105	97	28/29	95	116/122
• Easily accessible toilet facilities	97	125/129	91	96/105	97	28/29	97	118/122
• Appropriate aids to toileting (frames/rails etc)	97	125/129	81	85/105	97	28/29	98	119/122
• Privacy when staff speak to in-patients in confidence	81	105/129	60	63/105	93	27/29	93	113/122
• Privacy when staff speak to out-patients in confidence	91	118/129	94	99/105	83	24/29	41	50/122
• Steps taken to reduce odour	88	114/129	73	77/105	97	28/29	95	116/122
• Hand washing after toileting	98	126/129	97	102/105	97	28/29	98	119/122
• Other	8	10/129	4	4/105	31	9/29	3	4/122

Sites answering NO to question 5.1 were asked to state their areas of concern and the vast majority of these comments relate to concerns about the poor environment in which people have to perform continence assessments. Sites mentioned curtains, inadequate toilet and pad disposal facilities, and in one case, the removal of a specialist clinical facility. However, most sites appear happy about the measures taken for provision of care in a private and dignified manner.

User Evaluation of Service

There should be a means of assessing patient and carer satisfaction with the continence. User involvement at all levels of the service is actively sought by NICE, the Essence of Care and by the NSF for Older People. National policy for the care of older people puts an emphasis on privacy and dignity.

- To identify areas of improvement.
- To promote a service that is responsive to the needs of the patients and their families (Kelson 1995; 2001).

Examples

- Suggestions boxes with the means of feedback on progress
- Leaflets on "how to complain"
- User satisfaction surveys.

Table 32: User Evaluation of the Service

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
6.1 Are there means in the care setting by which continence service users/patients can make:								
6.1i Suggestions	84	126/150	88	103/117	84	26/31	89	109/122
6.1ii Complaints	97	146/150	98	115/117	97	30/31	91	111/122

There should be a means of auditing bladder and bowel care so that health bodies can compare their performance over time with national means and other similar units.

Good practice in continence services (DH, 2000) Chapter 7, 7.5: *All nursing and residential homes should be invited to participate in an annual clinical audit which allows them to compare their performance over time and with other similar homes.*

NSF recommends The Essence of Care as a continuous quality improvement tool.

Table 33: User Evaluation of the Service

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
6.2 Is the bladder or bowel care delivered by the service subject to regular audit?	50 YES 37 NO 13 NK	75/150 56/150 19/150	68 YES 26 NO 7 NK	79/117 30/117 8/117	42 YES 42 NO 16 NK	13/31 13/31 5/31	55 YES 20 NO 25 NK	67/122 24/122 31/122
6.2i If yes, does the audit assess the patient's concern regarding privacy and dignity?	71 YES 23 NO 7 NK	53/75 17/75 5/75	72 YES 23 NO 5 NK	57/79 18/79 4/79	77 YES 15 NO 8 NK	10/13 2/13 1/13	85 YES 6 NO 9 NK	57/67 4/67 6/67

Many sites now report participation in this audit as evidence of regular audit; still at best only 68% of sites report regular audit activity for their continence services.

Table 34: User Evaluation of the Service

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
6.3 Does the continence service have a user group?	15 YES 65 NO 19 NK	23/150 98/150 29/150	24 YES 71 NO 5 NK	28/117 83/117 6/117	6 YES 55 NO 39 NK	2/31 17/31 12/31	19 YES 36 NO 45 NK	23/122 44/122 55/122
6.3i If YES, is this group involved in service planning and delivery?	74	17/23	82	23/28	50	1/2	87	20/23
6.3ii Is this group a support group?	65	15/23	64	18/28	50	1/2	70	16/23

The recommendation for patient or user input into service delivery and development is seldom met.
Complaints should be reviewed as part of the process for service improvement. Attention to feedback via complaints is an essential part of clinical governance and is an important mechanism for improving the quality of care.

Table 35: User Evaluation of the Service

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
6.4 Does the continence service have a system in place for the review of any complaints made by the users/patients?	75 YES 13 NO 13 NK	112/150 19/150 19/150	97 YES 3 NO 1 NK	113/117 3/117 1/117	65 YES 10 NO 26 NK	20/31 3/31 8/31	52 YES 8 NO 39 NK	64/122 10/122 48/122

Continence Products

Good practice in continence services (DH, 2000) Chapter 3, 3.12: *There is an unacceptable variation amongst NHS Trusts in the type, quality and quantity of continence supplies made available to patients.*
They are an essential component of the management of incontinence that should normally only be issued after an initial assessment or when a management plan has been completed and reviewed.

Patients should have access to a full and appropriate range of products to assist in the management of their incontinence; including bed pads, a variety of sizes/absorbencies of body-worn pads with pants, disposable, reusable and all-in-one products. Products might include catheters, bags and anal plugs for example. This supply should be based upon clinical need. Absorbent garments and bed pads may be required while investigations and treatments are underway, or if continence is found to be intractable.

Table 36: Continence Products

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
7.1 To which NHS continence products do patients / residents have access?								
• Body worn pads (disposable)	97	145/150	100	117/117	97	30/31	90	110/122
• Body worn pads (re-usable)	14	21/150	50	59/117	19	6/31	9	11/122
• All-in-one disposable	79	119/150	98	115/117	84	26/31	65	79/122
• All-in-one (re-usable)	15	23/150	33	39/117	3	1/31	7	9/122
• Reusable products (pants)	34	51/150	82	96/117	55	17/31	52	63/122
• Other*	25	38/150	33	39/117	29	9/31	7	8/122

*Mentioned under 'others' were; pad delivery service/manufacturer (8), bed protection (33), catheters/intermittent indwelling (14), condom drainage devices (35), anal plugs/faecal collection services (17), urinals/bed pads/urinary collection devices (14), others (17)

Supply of products should be governed by clinical need and quality of life rather than product costs. Rationing of supplies should not be a feature of NHS services.

Continence products: any product or appliance that may be used to contain the involuntary or inappropriate passing of urine and/or faeces. This excludes pharmacological intervention and catheterisation.

Table 37: Continence Products

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
7.2 Does your written policy (1.1=YES) indicate that products are supplied on the basis of clinical and patient need rather than cost?	69 YES 16 NO 15 NK	42/61 10/61 9/61	84 YES 14 NO 2 NK	85/101 14/101 2/101	81 YES 13 NO 6 NK	13/16 2/16 1/16	74 YES 8 NO 18 NK	89/120 9/120 22/120

Consideration should be given to patient's choice of continence products (DoH, 2000).

Table 38: Continence Products

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
7.3 Are patients'/carers' views sought in selecting the range of products to be supplied?	42 YES 39 NO 19 NK	63/150 58/150 29/150	74 YES 21 NO 4 NK	87/117 25/117 5/117	58 YES 29 NO 13 NK	18/31 9/31 4/31	71 YES 26 NO 2 NK	87/122 32/122 3/122

Patient/carer involvement should be included in service development and delivery. Despite the low number of sites reporting user groups within their continence services (Table 34), more report seeking patient/carer views in selection of products; it is unclear if this is being done at the individual level (what the patient prefers for themselves) or in the broader context of what the user thinks is best for the service. The involvement of patients/carers in the delivery of services is part of Government policy for health care and is included within department of health guidance (DoH 2000).

Table 39: Continence Products

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
7.4 Is there a written policy for eliciting patient/carer views?	12 YES 66 NO 22 NK	18/150 99/150 33/150	30 YES 59 NO 11 NK	35/117 69/117 13/117	45 YES 39 NO 16 NK	14/31 12/31 5/31	32 YES 33 NO 35 NK	39/122 40/122 43/122

Good practice in continence services (DH, 2000) Chapter 3, 3.12. Continence products should be provided to meet the individual patient's need.

Table 40: Continence Products

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
7.5 Do you have a limit on the type of products supplied per day?	12 YES 64 NO 24 NK	18/150 96/150 36/150	66 YES 32 NO 2 NK	77/117 38/117 2/117	16 YES 77 NO 6 NK	5/31 24/31 2/31	55 YES 34 NO 11 NK	67/122 42/122 13/122
7.5ii What is the maximum number of products supplied per day?								
3	7	1/15	7	5/74	-	0/4	8	5/64
4	73	11/15	64	47/74	50	2/4	50	32/64
5	13	2/15	24	18/74	-	0/4	31	20/64
6-8	7	1/15	5	4/74	50	2/4	11	7/64
Median	FOUR		FOUR		FIVE		FOUR	
7.5iii Who is responsible for the imposition of this limit?								
• Local community service	84	16/19	90	71/79	86	6/7	46	35/76
• Care home provider	-	0/19	-	0/79	-	0/7	11	8/76
• Hospital trust	16	3/19	10	8/79	14	1/7	24	18/76
• Local authority	-	0/19	-	0/79	-	0/7	20	15/76
7.6 Who normally provides additional products?								
• The patient/ resident	30	45/150	72	84/117	23	7/31	16	20/122
• Family	27	40/150	57	67/117	29	9/31	18	22/122
• Care home	10	15/150	45	53/117	6	2/31	70	86/122
• Other *	21	31/150	21	25/117	45	14/31	4	5/122
• None required	29	44/150	17	20/117	19	6/31	12	15/122
• Not Known	21	31/150	3	3/117	16	5/31	3	4/122

*Mentioned under 'others' were; Hospital /Trust (30), Primary Care Trust/LHB (24), continence service/pad manufacturer (12), others (9)

Despite the majority of respondents indicating that written policies on product provision indicate that containment products are supplied on the basis of need, that there is user consultation on provision there is still evidence of widespread rationing outside of acute hospital and mental health care. Where rationing does occur, this is primarily the responsibility of primary care.

Patient/carer Information and Support

Patients and carers should have free access to evidence based information about bladder and bowel care. This could also be the information provided by specialist nurses, physiotherapists and consultants at initial or specialised assessments so that the patient/carer can make informed choices about treatment options.

Table 41: Patient/carer information and support

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
8.1 Is evidence-based information about bladder and bowel care freely available to patients and carers?	23 YA 64vYS 12 NO 1 NK	34/150 96/150 18/150 2/150	55 YA 41 YS 4 NO 0 NK	65/117 47/117 5/117 0/117	26 YA 55 YS 13 NO 6 NK	8/31 17/31 4/31 2/31	45 YA 27 YS 20 NO 7 NK	55/122 33/122 25/122 9/122

Key: YA: Yes, All areas; YS: Yes, Some areas

To promote patients' and carers' understanding of continence and enable shared decision-making when treatment options are involved: Patient leaflets may be either locally or nationally produced. (For example those produced by the Bladder and Bowel Foundation, Age concern/Help the Aged / Parkinson's Disease Society, pharmaceutical companies) They should be freely available within the facility.

Patient: for the purposes of this audit, the term patient refers to patients, carers and any other user of the service.

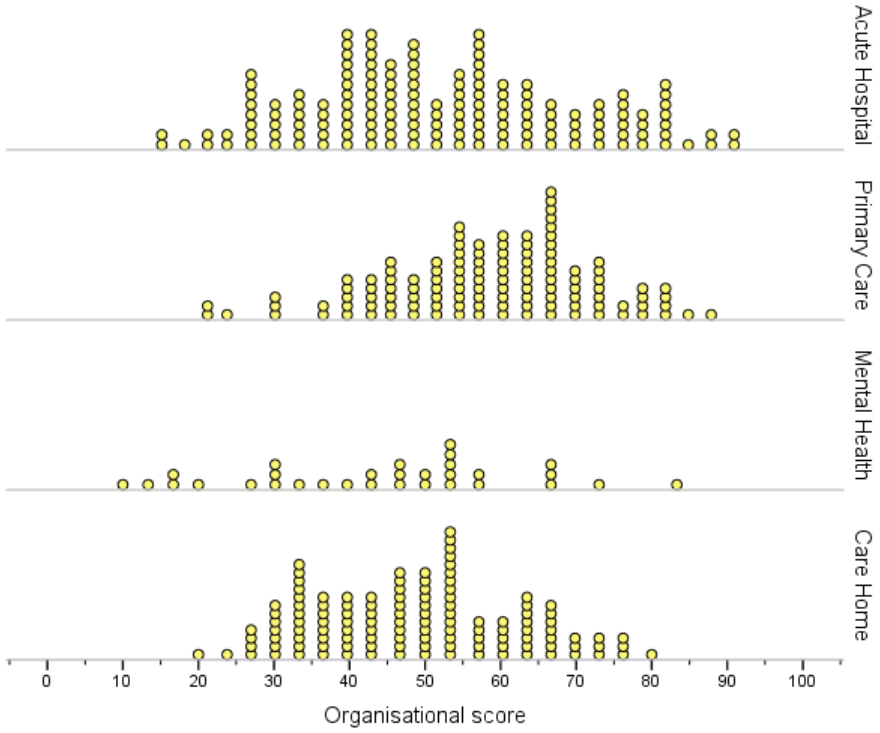
Such information should reflect the nature of the population that the facility serves. There will be differences in supply according to clinical area.

Table 42: Patient/carer information and support

	Acute (Hospital)		Primary Care		Mental Health		Care Home	
	%	N	%	N	%	N	%	N
8.2 Does the facility utilise patient information literature e.g. from charities to promote continence?	78 YES 15 NO 7 NK	117/150 22/150 11/150	91 YES 5 NO 4 NK	106/117 6/117 5/117	58 YES 26 NO 16 NK	18/31 8/31 5/31	33 YES 50 NO 17 NK	40/122 61/122 21/122

Overall Organisational Score

The audit questions used for the overall scoring are given in Appendix scoring system adopted for these questions. The plot below displays site variation in these overall organisational scores for each sector. The higher the score the better the score.



The Table below gives the range of scores for each sector that approximate best to the lowest (worst) quartile of scores, middle half of scores and upper (better) quartile of scores. The last column indicates whether your site falls into the upper or lower quartiles or within the middle half of scores for your sector.

Table 43:

	Acute Hospital	Primary Care	Mental Health	Care Home
Lower Quartile	15-38	21-49	10-29	20-35
Middle Half*	39-64	50-67	30-53	36-57
Upper Quartile	65-91	68-88	54-83	58-80
MEDIAN score	50	61	47	50

*Inter-Quartile Range

Organisational Audit Temporal Comparisons

Over the three rounds of audit: 2005, 2006 and 2009 for the acute hospital sector in England

Questions that were the same, or very nearly the same, from the National audits of Continence Care for Older people and the current round of audit were compared across time. The 2005 and 2006 data were revisited and re-analysed to gain as much comparability as possible. Nevertheless there was a differing mix of hospitals making up each cross-sectional set of results and so strictly speaking the comparisons are not entirely like for like. These results show that, over the time of the audits there has been an increase in the number of hospitals achieving many of the required standards in the organisation of care. The proportion of hospitals routinely offering an assessment of continence is still low, at 54%, but has increased from 40% in 2005. However, the rate of progress seems slow (integrated services), and in some cases, non existent (training) given the existence of national guidelines for practice (NICE) and a model of preferred service provision.

Table 45:

Question	2005		2006		2010	
	%	N	%	N	%	N
Does the facility utilise an Integrated care pathway or an evidence based treatment algorithm for patients with incontinence?						
Integrated Care Pathway	21	36/168	25	40/157	38	57/151
Algorithm	18	30/168	29	45/157	44	66/151
Care Plan	41	69/168	41	65/157	52	79/151
None of these	36	61/168	31	49/157	24	37/151
Is it the facility's practice to ask a screening question relating to bladder and bowel problems as part of the initial assessment?	90	151/168	94	147/157	96	145/151
Is there a written protocol for providing a basic assessment for all people who indicate that they have problems with urinary and/or faecal continence?	40	67/168	50	79/157	54	82/151
Does the clinical team include a practitioner who has had training to:						
Take a continence history?	76	127/168	85	133/157	90	136/151
Initiate a frequency-volume chart?	71	120/168	84	132/157	89	134/151
Perform a rectal examination?	90	152/168	94	147/157	95	143/151
Perform a urinalysis?	99	166/168	99	155/157	99	150/151
Does the facility have access to an integrated continence service? (as defined by “Good Practice in continence services”) (DoH 2000)	46	77/168	58	90/156	56	84/151

Table 46:

Question	2005		2006		2010	
	%	N	%	N	%	N
Is there a structured programme of staff training on promoting continence for the facility?	45	76/168	52	81/157	49	74/151
Do patients have access to a local continence practitioner, who is able to give advice on continence, and bladder and bowel care?	88	148/168	90	142/157	94	142/151
If YES, is the practitioner:						
Hospital based	43	60/141	30	43/141	58	82/142
Community based	57	81/141	70	98/141	83	118/142
Is a specialist continence assessment always carried out by a practitioner with training in?						
• Knowledge of aetiology of urinary/faecal incontinence	68	113/167	75	117/157	79	120/151
• Experience in taking history	74	124/168	80	126/157	79	120/151
• Able to perform urinalysis	81	136/168	82	129/157	79	119/151
• Able to do residual volume measurement	71	120/168	74	116/157	75	114/151
What is the number of whole time equivalent continence practitioners available to you?	Median 2.0 IQR 1.0-3.0 N = 89 sites		Median 1.5 IQR 1.0-2.7 N = 89 sites		Median 2.3 IQR 1.0-3.0 N = 78 sites	
PCT	83% (74/89) with WTE>0		84% (75/89) with WTE>0		96% (75/78) with WTE>0	
What is the number of whole time equivalent continence practitioners available to you?	Median 0.5 IQR 0 to 1.0 N = 112 sites		Median 0.5 IQR 0 to 1.0 N = 119 sites		Median 0.8 IQR 0 to 1.6 N = 123 sites	
Hospital Service	58% (65/112) with WTE>0		55% (65/119) with WTE>0		61% (75/123) with WTE>0	

Table 47:

Questions	2005		2006		2010	
	%	N	%	N	%	N
Are there means in the care setting by which continence service users/patients can make:						
Suggestions	79	130/165	83	130/156	84	127/151
Complaints	98	162/165	96	150/156	97	147/151
Is the bladder or bowel care delivered by the service subject to regular audit?	33	44/132	46	65/140	57	75/131
Does the continence service have a user group?	18	22/121	20	24/123	19	23/122
Are patients'/carers' views sought in selecting the range of products to be supplied?	47	64/137	38	55/143	52	63/122
Is evidence-based information about bladder and bowel care freely available to patients and carers?						
Some areas	62	102/165	68	102/151	64	96/149
All areas	15	24/165	18	27/151	23	35/149

The following analyses relate to questions from the last 2 audits which were different in phraseology but, in the opinion of the Steering Committee, had the same meaning. Once again, the results arre promising and there has, in the majority of cases been an increase in the number of sites reaching the standard.

Almost the same questions:

Table 48:

Audit	Question	%	N
2005	Does the facility (GP practice/ hospital /care home), or the continence service covering the facility, have a written policy for the management of continence?	27	45/168
2006	Does the hospital or the service covering the facility, have a written policy for the management of continence?	37	57/156
2008	Does the facility (GP practice/hospital ward/care home),or the service covering the facility, have a written policy for the management of continence?	41	62/151

Table 49

Audit	Question	%	N
2005	Does your written policy indicate that products are supplied on the basis of clinical and patient need rather than cost?	71	32/45
2006	Does the written policy indicate that products are supplied on the basis of clinical and patient need rather than cost?	81	44/54
2008	Does the written policy indicate that products are supplied on the basis of clinical and patient need rather than cost??	81	43/53

BLADDER AND BOWEL

CLINICAL AUDIT

FULL NATIONAL RESULTS

This section gives all the results of the Bladder and Bowel clinical audit.

Each data table is accompanied with its relevant guideline and a commentary. The data for each care setting are shown. No site specific data are presented.

Table 87: Trust participation in the Clinical audit

Region	Type of TRUSTS	Trusts Eligible to Participate 2009	Trusts registered 2009 (% of eligible)	Trusts participating 2009 (% of eligible)	Sites participating 2009	2006 Audit Participation (trust level)
England	Acute	161	143 (89%)	128 (80%)	141	83%
	Primary Care	144	96 (67%)	75 (52%)	85	43%
	Mental Health	57	35 (61%)	24 (42%)	26	45%
Wales	Combined	7	6 (86%)	6 (86%)	11	69%
Northern Ireland	Combined	5	2 (40%)	2(40%)	5	44%
Islands	Combined	2	2 (100%)	2 (100%)	3	67%

Although it was recommended that primary care entered GP practices into the audit, some audited and entered their hospital sites. For the organisational audit; this made no difference to the analysis; for the clinical audit, data were analysed according to their actual care setting.

Table 88: Care Homes

	Registered	Participated (% registered)
Barchester	200	75 (38%)
Anchor Trust	13	0 (0%)
Care Homes Overall	213	75 (35%)

Again, for the purposes of analysis by sector the combined trusts of Wales. Northern Ireland and the Islands were merged in with the Primary Care Trusts of England to form the Primary Care sector in the national analysis.

BLADDER FULL NATIONAL RESULTS

Symptoms

Table 1: Symptoms

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
1.1 Does the patient have:** **%YES**								
• Nocturnal frequency (>2 voids /night)	34	1119	40	1052	40	217	69	753/1094
• Urinary frequency (>8 voids/24h)	35	1154	41	1062	29	154	55	605/1094
• Nocturnal enuresis	21	699	29	764	32	174	43	477/1097
• Urinary urgency	37	1215	48	1254	22	119	31	341/1099
• Urgency (urge) incontinence	35	1148	45	1171	24	131	31	335/1095
• Stress urinary incontinence (urine loss with coughing, straining, exertion)	24	778	30	779	12	62	31	340/1094
• Post micturition dribble (MEN)	18	228/1271	21	172/826	11	26/244	33	103/312
• Clinically significant post void residual volume	16	533	10	251	0.7	4	3	29/1051
• Voiding difficulty	24	774	15	399	5	26	7	76/1085
• Intermittent catheter	8	248	3	73	0.6	3	0.6	7/1130
• Permanent catheter	16	524	6	153	4	21	10	115/1134
• Constipation	20	641	20	513	23	126	36	414/1136
• Bladder pain	8	264	4	105	0.9	5	3	39/1129

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
1.1 Does the patient have:** **%YES**								
• Nocturnal frequency (>2 voids /night)	34	949	34	645	34	39	61	40/66
• Urinary frequency (>8 voids/24h)	46	1300	47	883	33	38	59	39/66
• Nocturnal enuresis	13	366	19	360	39	45	29	19/65
• Urinary urgency	54	1517	54	1011	20	23	27	18/66
• Urgency (urge) incontinence	46	1307	46	872	13	15	29	19/66
• Stress urinary incontinence (urine loss with coughing, straining, exertion)	55	1561	47	889	11	12	15	10/66
• Post micturition dribble (MEN)	21	117/559	20	87/445	9	4/45	6	2/32
• Clinically significant post void residual volume	13	369	12	228	0.9	1	3	2/63
• Voiding difficulty	23	645	20	370	3	3	-	0/64
• Intermittent catheter	8	216	6	111	0.9	1	1	1/67
• Permanent catheter	7	198	3	63	3	3	28	19/68
• Constipation	12	350	16	295	20	23	28	19/68
• Bladder pain	10	284	5	90	2	2	1	1/67

****** Denominators excludes care home residents with 'Records not available'

For the younger cohort, the symptoms of urgency, frequency, urgency incontinence and stress urinary incontinence predominate in acute hospitals and primary care. In mental health and care home settings, nocturnal enuresis and urinary frequency are significant problems.

For older people, these findings are replicated; nocturia and nocturnal enuresis are commonly encountered problems in mental health and care homes. The distribution of people with voiding difficulty reflects the nature of the inpatient population.

Action: Training course organisers should ensure that programme content reflects the likely problems encountered in the care setting.

NICE CG 40: Chapter 3. Assessment and investigations, 3.2: Grade D, Good Practice Point (GPP): *The clinical assessment should seek to identify relevant predisposing and precipitating factors and other diagnoses that may require referral for additional investigation and treatment. There are many co-existing conditions that have an adverse impact on continence status or may have an impact upon management and outcome from treatment.*

The 65+ group have, as might be expected, many associated co-morbidities, spanning the major organ systems. Impaired mobility dominates the profile outside of mental health care and care homes, and within these dementia, depression and recurrent falls are common associated conditions.

Table 2: Symptoms: other conditions

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
1.2 What other documented conditions does the patient have either currently or in the past? **%YES**								
• Bladder cancer/stones	4	118	3	76	0.9	5	2	24
• Chronic cough	4	143	5	122	2	10	4	49
• Dementia	21	705	19	496	70	376	58	666
• Depression	9	294	7	192	33	177	21	238
• Diabetes	16	530	16	431	19	103	13	143
• Faecal loading or chronic constipation	8	251	5	125	10	54	8	95
• Heart failure	12	401	12	318	9	50	14	164
• Hypertension	33	1074	27	694	30	161	25	285
• Impaired mobility	33	1076	29	760	34	181	59	675
• Neurological disease	12	397	12	307	10	55	12	140
• Obesity	4	148	4	116	5	27	9	107
• Urogenital atrophy (WOMEN)	4	88/2011	3	53/1786	-	0/295	0.1	1/811
• Pelvic radiotherapy	1	39	0.6	15	-	0	0.2	2
• Pelvic surgery e.g. hysterectomy (WOMEN)	19	386/2011	14	257/1786	6	16/295	3	26/811
• Prolapse (WOMEN)	12	238/2011	7	127/1786	2	7/295	2	17/811
• Prostate disease or surgery (MEN)	35	445/1271	34	282/826	11	28/244	22	73/328
• Recurrent falls	15	505	9	245	22	118	21	242
• Spinal cord disease/trauma	2	83	3	84	2	13	1	14
• Smoking	5	173	4	99	7	36	4	49
• Stroke	16	509	13	352	11	57	26	293
• Trauma at childbirth (WOMEN)	2	34/2011	2	32/1786	0.7	2/295	0.6	5/811
• Acute urinary tract infection	20	648	10	261	17	91	13	148
• Other*	28	908	29	755	19	101	11	120

*Others(Acute Hospital) –Alcohol related disease 19, Other renal impairment or disease 89, Other gynaecological disease or disorder 21, Other gastroenterological disease or disorder 133, Non-specific and other malignancies 35, Delirium 8, Haematological disorders 40, Retention of urine 12, Mental health diagnoses 24, Other urological surgery or disease 62, Learning disability 8, Other endocrine disease or disorder 48, Other respiratory disease or disorder 158, Other cardiac disease or disorder 149, Other vascular (non-cardiac) disease or disorder 44, Other musculoskeletal disease including fracture & Osteoporosis 183, Others 78

*Others(Primary Care) –Alcohol related disease 2, Other renal impairment or disease 92, Other gynaecological disease or disorder 24, Other gastroenterological disease or disorder 108, Non-specific and other malignancies 37, Other problems related to childbirth 1 , Delirium 9, Haematological disorders 21, Retention of urine 5, Mental health diagnoses 32, Other urological surgery or disease 39, Learning disability 8, Other endocrine disease or disorder 41, Other respiratory disease or disorder 100, Other cardiac disease or disorder 90, Other vascular (non-cardiac) disease or disorder 22, Other musculoskeletal disease including fracture & Osteoporosis 198, Others 74

*Others(Mental Health) – Other renal impairment or disease 11, Other gynaecological disease or disorder 1, Other gastroenterological disease or disorder 12, Non-specific and other malignancies 2, Delirium 1, Haematological disorders 1, Mental health diagnoses 23, Other urological surgery or disease 5, Learning disability 3, Other endocrine disease or disorder 3, Other respiratory disease or disorder 12, Other cardiac disease or disorder 5, Other vascular (non-cardiac) disease or disorder 6, Other musculoskeletal disease including fracture & Osteoporosis 15 , Others 16

*Others(Care Homes) –Alcohol related disease 2, Other renal impairment or disease 17, Other gynaecological disease or disorder 2, Other gastroenterological disease or disorder 8, Non-specific and other malignancies 15, Delirium 1, Haematological disorders 5, Retention of urine 1, Mental health diagnoses 11, Other urological surgery or disease 2, Learning disability 2, Other endocrine disease or disorder 1, Other respiratory disease or disorder 12, Other cardiac disease or disorder 9, Other vascular (non-cardiac) disease or disorder 5, Other musculoskeletal disease including fracture & Osteoporosis 21, Others 15.

For those aged under 65 years, depression, neurological disease, and hypertension predominate as associated conditions across the settings. High numbers of women with prolapse and men having had prostate surgery are noted within acute hospitals and primary care. Dementia and impaired mobility are common associated conditions within the mental health and care home settings.

<65	**Acute (Hospital) N=2813**		**Primary Care N=1880**		**Mental Health N=114**		**Care Home N=68**	
	%	**N**	**%**	**N**	**%**	**N**	**%**	**N**
1.2 What other documented conditions does the patient have either currently or in the past? **%YES**								
• Bladder cancer/stones	2	50	0.7	13	-	0	1	1
• Chronic cough	4	99	3	59	4	5	6	4
• Dementia	1	35	1	21	13	15	26	18
• Depression	11	323	13	237	27	31	19	13
• Diabetes	7	185	9	164	11	13	15	10
• Faecal loading or chronic constipation	4	106	3	57	9	10	6	4
• Heart failure	1	38	2	36	4	4	1	1
• Hypertension	12	350	9	178	12	14	7	5
• Impaired mobility	9	241	13	236	21	24	53	36
• Neurological disease	13	368	22	419	8	9	49	33
• Obesity	9	243	8	151	18	21	12	8
• Urogenital atrophy (WOMEN)	2	50/2254	2	28/1435	-	0/69	-	0/34
• Pelvic radiotherapy	0.9	26	0.5	10	-	0	-	0
• Pelvic surgery e.g. hysterectomy (WOMEN)	25	556/2254	14	205/1435	7	5/69	-	0/34
• Prolapse (WOMEN)	15	339/2254	7	106/1435	4	3/69	3	1/34
• Prostate disease or surgery (MEN)	16	88/559	16	71/445	2	1/45	-	0/34
• Recurrent falls	0.9	24	0.9	16	8	9	3	2
• Spinal cord disease/trauma	5	146	5	95	3	3	3	2
• Smoking	10	270	9	173	32	37	10	7
• Stroke	3	79	3	61	6	7	10	7
• Trauma at childbirth (WOMEN)	8	180/2254	9	129/1435	1	1/69	-	0/34
• Acute urinary tract infection	10	288	6	121	17	19	13	9
• Other*	24	670	25	469	33	38	16	11

*Others(Acute Hospital) –Alcohol related disease 33, Other renal impairment or disease 24, Other gynaecological disease or disorder 72, Other gastroenterological disease or disorder 110, Non-specific and other malignancies 18, Other problems related to childbirth 15, Delirium 3, Haematological disorders 18, Retention of urine 5, Mental health diagnoses 57, Other urological surgery or disease 74, Learning disability 15, Other endocrine disease or disorder 40, Other respiratory disease or disorder 82, Other cardiac disease or disorder 31, Other vascular (non-cardiac) disease or disorder 8, Other musculoskeletal disease including fracture & Osteoporosis 71, Others 87

*Others(Primary Care) –Alcohol related disease 14, Other renal impairment or disease 27, Other gynaecological disease or disorder 27, Other gastroenterological disease or disorder 77, Non-specific and other malignancies 10, Other problems related to childbirth 2, Delirium 2, Haematological disorders 6, Mental health diagnoses 44, Other urological surgery or disease 35, Learning disability 44, Other endocrine disease or disorder 29, Other respiratory disease or disorder 71, Other cardiac disease or disorder 18, Other vascular (non-cardiac) disease or disorder 4, Other musculoskeletal disease including fracture & Osteoporosis 71, Others 51

*Others(Mental Health) –Alcohol related disease 1, Other gastroenterological disease or disorder 1, Delirium 1, Mental health diagnoses 20, Other urological surgery or disease 4, Learning disability 5, Other respiratory disease or disorder 1, Other cardiac disease or disorder 1, Other vascular (non-cardiac) disease or disorder 1, Other musculoskeletal disease including fracture & Osteoporosis 2, Others 4

*Others(Care Homes) – Non-specific and other malignancies 1, Mental health diagnoses 3, Learning disability 5, Others 2

NICE CG 40: Key recommendation. Chapter 3. Assessment and investigations, 3.2: Grade D, (GPP): *At the initial clinical assessment the women's urinary incontinence (UI) should be categorised as stress UI, mixed UI, or urge UI/ overactive bladder (OAB).*

Table 3: Type/cause of urinary incontinence

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence? **% YES**								
Stress urinary incontinence	14	451	14	353	6	33	11	124
Mixed urinary incontinence	13	413	21	537	12	66	25	280
Passive leakage	6	208	7	179	10	53	8	91
Urgency urinary Incontinence	18	596	23	611	9	46	13	152
Detrusor overactivity / overactive bladder)	10	321	8	219	0.4	2	2	19
Functional	10	323	17	432	22	120	39	441
Urinary tract infection	15	494	10	254	16	84	11	126
Voiding difficulty	18	594	12	317	4	21	4	46
Urogenital atrophy	2	54	2	42	0.4	2	-	0
Other*	2	68	2	61	1	7	3	6
No diagnosis documented	29	961	22	574	42	229	26	299

*Others (Acute Hospitals) – Retention of urine 31, Enuresis 6, Adverse affect of medication 4, Outflow tract disease 22, Catheter problems 5

*Others (Primary Care) – Retention of urine 12, Enuresis 20, Adverse affect of medication 4, Outflow tract disease 19, Catheter problems 7

*Others (Mental Health) – Retention of urine 1, Adverse affect of medication 3, Outflow tract disease 2, Catheter problems 1

*Others (Care Homes) – Retention of urine 2, Enuresis 1, Adverse affect of medication 2, Catheter problems 1

No diagnosis was documented in a large proportion of older cases, ranging from 19% in primary care to 38% in mental health care, potentially either indicating a reduced rate of assessment or limiting the potential for treatment.

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence? **% YES**								
Stress urinary incontinence	37	1030	28	528	9	10	6	4
Mixed urinary incontinence	25	699	26	493	4	5	18	12
Passive leakage	5	142	4	80	3	3	1	1
Urgency urinary Incontinence	21	602	24	455	10	11	10	7
Detrusor overactivity / overactive bladder)	15	425	13	245	4	5	4	3
Functional	3	85	9	171	18	20	24	16
Urinary tract infection	8	220	8	144	16	18	10	7
Voiding difficulty	15	426	16	304	4	4	3	2
Urogenital atrophy	1	31	1	25	-	0	-	0
Other*	2	53	2	39	3	3	-	0
No diagnosis documented	10	274	10	195	46	53	40	27

*Others (Acute Hospitals) – Interstitial cystitis 5, Retention of urine 25, Enuresis 8, Adverse affect of medication 1, Outflow tract disease 12, Catheter problems 2

*Others (Primary Care) – Interstitial cystitis 3, Retention of urine 7, Enuresis 14, Adverse affect of medication 2, Outflow tract disease 10, Catheter problems 2, Other 1

*Others (Mental Health) –Adverse affect of medication 3

For younger people in acute hospitals or primary care with an identified cause for their incontinence: stress incontinence, incontinence with mixed symptoms and urgency incontinence comprise the majority of diagnoses.

Action: Clinicians should ensure that a working diagnosis is documented to guide others in further management

Table 4: Assessment – Cognitive status

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
1.4 Has the patient's cognition been assessed?** **%YES**	66	1628/2484	70	1356/1945	95	484/510	78	815/1044
1.4i Is the patient's cognitive status:								
• Insufficient information to calculate	29	938	35	918	9	46	2	19
If calculable:								
• Unimpaired	51	1196/2344	55	934/1694	11	53/493	15	164/1120
• Mild	16	376/2344	20	337/1694	14	70/493	23	258/1120
• Moderate	18	420/2344	16	275/1694	37	180/493	31	348/1120
• Severe	15	352/2344	9	148/1694	39	190/493	31	350/1120
1.4ii Is there documented use of a formal scoring system for assessment of cognition? **% YES**	60	973/1628	34	460/1356	82	399/484	52	423/815

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
1.4 Has the patient's cognition been assessed?** **%YES**	44	845/1919	64	826/1299	89	78/88	90	57/63
1.4i Is the patient's cognitive status:								
• Insufficient information to calculate	32	898	35	667	27	31	4	3
If calculable:								
• Unimpaired	90	1725/1915	85	1025/1213	19	16/83	17	11/65
• Mild	4	81/1915	6	76/1213	24	20/83	22	14/65
• Moderate	3	57/1915	4	51/1213	19	16/83	35	23/65
• Severe	3	52/1915	5	61/1213	37	31/83	26	17/65
1.4ii Is there documented use of a formal scoring system for assessment of cognition? **% YES**	22	182/845	27	220/826	73	57/78	56	32/57

**Denominators exclude those with data stated as being 'Not documented'

A cognitive assessment of some sort was performed for 44% of <65s in acute care, and 66% in primary care. For the vast majority (85 - 90%) in acute hospitals and primary care, there was no detected impairment, the reverse being true (small numbers) in the mental health and care home settings. Formal assessment scales were used infrequently in acute and primary care. For older people, cognitive assessment was notably more common in acute hospitals (66%) as was the use of formal assessment scales. Rates of cognitive impairment were higher in each setting.

Table 5: Assessment – Functional status

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
1.5 Has the patient's functional ability been assessed?** **%YES**	75	1996/2660	79	1634/2071	91	433/476	85	843/994
1.5i Is the patient's functional status:								
• Insufficient information to calculate	24	778	30	793	14	74	6	65
If calculable:								
• Unimpaired	32	796/2504	33	596/1819	9	41/465	7	70/1074
• Mild	21	528/2504	27	483/1819	18	82/465	21	226/1074
• Moderate	31	770/2504	30	543/1819	43	202/465	39	418/1074
• Severe	16	410/2504	11	197/1819	30	140/465	34	360/1074
1.5ii Is there documented use of a formal scoring system for assessment of functional ability? **%YES**	34	687/1996	28	454/1634	55	239/433	43	366/843

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
1.5 Has the patient's functional ability been assessed?** **%YES**	51	1019/1992	71	994/1401	86	77/90	85	51/60
1.5i Is the patient's functional status:								
• Insufficient information to calculate	30	855	31	590	31	35	6	4
If calculable:								
• Unimpaired	80	1572/1958	66	854/1290	18	14/79	14	9/64
• Mild	7	130/1958	13	166/1290	19	15/79	17	11/64
• Moderate	8	159/1958	13	165/1290	27	21/79	33	21/64
• Severe	5	97/1958	8	105/1290	37	29/79	36	23/64
1.5ii Is there documented use of a formal scoring system for assessment of functional ability? **%YES**	19	189/1019	21	207/994	57	44/77	47	24/51

**Denominators exclude those with data stated as being 'Not documented'

Assessment of physical function is generally higher for the older group. This is appropriate. There are few formal assessment scales used in any setting.

NICE CG 40: Key recommendation. Chapter 3. Initial Assessment and Investigation, Grade D, (GPP): *At the initial clinical assessment the women's urinary incontinence (UI) should be categorised as stress UI, mixed UI, or urge UI/ overactive bladder (OAB).*

Table 6: Assessment – History

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.1 Is there documented evidence of a continence history? **%YES**	62	2019	80	2099	58	312	69	781
2.1i Does the history of urinary continence include:** **%YES**								
Daytime symptoms	80	1615	84	1773	82	256	93	697/749
Nocturnal symptoms	72	1445	81	1690	80	249	92	693/750

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.1 Is there documented evidence of a continence history? **%YES**	84	2358	86	1615	74	84	72	49
2.1i Does the history of urinary continence include:** **%YES**								
Daytime symptoms	88	2071	90	1446	75	63	93	42/45
Nocturnal symptoms	74	1735	79	1281	76	64	91	41/45

****** Denominators excludes care home residents with 'Records not available'

The proportion of the 65+ year old group who have a history taken in hospitals and mental health care is lower than in the younger group. The unavailability of records in some care homes appears to be a significant problem if there are not adequate records by which care can be directed.

Action: Clinicians should ensure that older people with either urinary incontinence or LUTS have a history taken.

The association of incontinence of faeces and urine is common in later life and with high dependency. Evidence for this should be sought and appropriately managed (consensus guidelines).

Table 7: Assessment – Incontinent of faeces

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.2 Is it documented that the patient is incontinent of faeces? **%YES**	17	569	15	380	32	173	49	560

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.2 Is it documented that the patient is incontinent of faeces? **%YES**	6	182	9	167	33	38	69	47

Unsurprisingly in acute hospitals and primary care, the distribution of co-existent faecal incontinence is higher in the older cohort. Rates are highest regardless of age in mental health and care home settings that are associated with increased morbidity and dependency.

Table 8: Assessment – bowel habit

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.3 Is the patient's bowel habit documented? **%YES**	60	1981	69	1793	56	301	86	982

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.3 Is the patient's bowel habit documented? **%YES**	53	1479	66	1250	46	53	87	59

There is a paucity of recording of bowel habit for all outside of care homes.

NICE CG 40: Key recommendation. Chapter 3. Assessment and investigations, bladder diaries, 3.9: Grade D, (GPP): *Bladder diaries should be used in the initial assessment with women with UI or OAB. Women should be encouraged to complete a minimum of 3 days of the diary, covering variations in their usual activities, such as both working and leisure days.*

Table 9: Assessment – bladder diary

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.4 Is there evidence of the use of a three day bladder diary?(WOMEN) ** **%YES**	29	497/1718	47	763/1640	23	38/168	33	170/508

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.4 Is there evidence of the use of a three day bladder diary?(WOMEN) ** **%YES**	44	977/2209	56	781/1393	19	10/54	61	14/23

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

The bladder diary is still used for, at best, half of those under investigation for UI, regardless of age. Those in mental health care are least likely to have a bladder diary – given the case mix in these institutions; this may be an entirely pragmatic response.

NICE CG 97: 4.6.2: *At initial assessment, ask men with bothersome LUTS to complete a urinary frequency volume chart. At specialist assessment, ask men with LUTS to complete a urinary frequency volume chart.*

Table 10: Assessment – bladder diary

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.5 Is there documented evidence of the use of any bladder diary**? ** %YES**	30	840/2836	46	1121/2416	26	84/320	32	229/724

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary

Rates for men were lower, at 21%, 43%, 22% and 29% respectively

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.5 Is there documented evidence of the use of any bladder diary**? ** %YES**	44	1210/2745	53	958/1812	22	17/79	30	15/50

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

Rates for men were lower, at 29%, 46%, 19% and 29% respectively

The documented use of any bladder diary in men occurs at best in half of the cases in primary care. A lower proportion of older men appear to have one in clinical practice.

Action: Clinicians should ensure that, wherever possible, a bladder diary is used both as part of assessment of the condition and in monitoring progress with treatment

A medication review is very valuable and recommended by NICE for both men and women as an adjunct to the history as part of the initial assessment for incontinence.

Table 11: Assessment – medication

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.6 Is the patient on medication that may exacerbate urinary incontinence? **%YES**	24	778	30	789	28	149	28	316
2.6i Has this medication been altered to minimise its impact? **** %YES**								
• Yes	29	223/767	23	181/777	18	27/148	26	79/307
• No	38	292/767	36	276/777	18	27/148	18	55/307
• Not able to minimise further	33	252/767	41	320/777	64	94/148	56	173/307

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.6 Is the patient on medication that may exacerbate urinary incontinence? **%YES**	9	264	18	331	26	30	12	8
2.6i Has this medication been altered to minimise its impact? **** %YES**								
• Yes	23	59/260	21	69/325	32	9/28	29	2/7
• No	40	104/260	34	111/325	14	4/28	14	1/7
• Not able to minimise further	37	97/260	45	145/325	54	15/28	57	4/7

**Denominators exclude those with data stated as being 'Not documented'

A greater number of older people take medication that might have an impact on continence status and across the acute hospital and primary care sectors, they are just as likely to have any alteration made to minimise its impact than younger people.

Action: A medication review should be performed for all those with bladder problems. This is important for the elderly, and particularly so if antimuscarinic medication is likely to be prescribed for the condition.

NICE CG 40: Chapter 3. Assessment and investigation, symptom scoring and quality of life assessment, 3.8: Grade D, (GPP): *The following incontinence-specific quality of life scales are recommended when therapies are being evaluated: ICIQ-SF Bristol Female Lower Urinary Tract Symptoms (BFLUTS), I-QoL, SUIQQ, UISS, SEAPI-QMM, ISI and Kings Health Questionnaire (KHQ). Examples of most commonly used Quality of Life (QoL) questionnaires are:* ***Kings Health Questionnaire, Bristol Female Lower Urinary Tract Symptoms, I-QoL or ICIQ-SF****.*

Table 12: Assessment – impact of symptoms on quality of life

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.7 Is there evidence that the impact of symptoms on quality of life has been assessed? ** **%YES**	36	1003/2768	52	1231/2387	44	126/285	59	418/708

Denominators exclude those with data stated as being 'NO, but** patient is mentally incompetent to undergo assessment

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.7 Is there evidence that the impact of symptoms on quality of life has been assessed? ** **%YES**	49	1316/2710	65	1177/1818	63	50/80	60	24/40

Denominators exclude those with data stated as being 'NO, but** patient is mentally incompetent to undergo assessment

Table 13: Assessment – quality of life assessment (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
2.8 Is there documented evidence that the impact of symptoms on quality of life has been recorded using a standard assessment scale? (WOMEN) ** **%YES**	13	222/1708	28	459/1623	18	30/153	27	139/510

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to undergo assessment

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
2.8 Is there documented evidence that the impact of symptoms on quality of life has been recorded using a standard assessment scale? (WOMEN) ** **%YES**	20	429/2187	40	550/1390	28	14/50	58	11/19

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

The impact of LUTS on quality of life is acknowledged to be high. It is unfortunate that this is seldom taken into account for many with the problem, particularly women, who have the highest prevalence of UI. Also, given that older people often experience a more severe impact, they appear to be less likely to have this area explored.

NICE CG 97: 4.4.2: p83: *Offer men considering any treatment for LUTS an assessment of their baseline symptoms with a validated symptom score (for example, the IPSS) to allow assessment of subsequent symptom change.*

Table 14: Assessment – validated symptom score (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
2.9 Is there evidence of the use of a validated symptom score at initial assessment? (MEN) ** **%YES**	13	141/1064	25	184/743	20	25/126	25	46/184

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
2.9 Is there evidence of the use of a validated symptom score at initial assessment? (MEN) ** **%YES**	18	94/520	29	119/408	29	8/28	21	4/19

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

The IPSS is a simple baseline assessment of symptoms which requires little expense in terms of time and is a useful way of monitoring symptom response. Although these data do not indicate the proportion of men having treatment, the overall use of validated scoring appears to be below that which one might expect in all sectors, regardless of age.

NICE CG 97: Recommendation 4.5: *At initial assessment, offer men with LUTS a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE). Offer men with LUTS having specialist assessment a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE).*
Consensus guidelines based upon recommendations from ***Good Practice in Continence Services (DH 2000).*** *Men with lower urinary tract symptoms (LUTS) should undergo digital rectal examination.*
NICE CG 40: Chapter 3. Assessment and Examination: *Pelvic assessment is important and should include vaginal examination, and possibly also rectal examination if clinically indicated.*

Table 15: Examination – Indication for rectal examination

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.10 Is there a documented indication for rectal examination? **%YES**								
Assessment of prostate size (MEN)	41	520/1271	25	203/826	8	20/244	13	42/328
Constipation	20	644	14	354	14	76	12	132
Voiding difficulty	15	488	8	205	4	23	4	41
Retention of urine	14	452	6	150	8	41	5	56
Not documented	61	2014	76	1981	80	431	84	958

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.10 Is there a documented indication for rectal examination? **%YES**								
Assessment of prostate size (MEN)	43	238/559	21	93/445	4	2/45	-	0/34
Constipation	12	327	11	202	6	7	9	6
Voiding difficulty	14	396	10	194	2	2	-	0/68
Retention of urine	9	258	7	128	4	5	3	2
Not documented	73	2055	77	1445	89	102	90	61

*Consensus guidelines based upon recommendations from **Good Practice in Continence Services (DH 2000).***
Men with lower urinary tract symptoms (LUTS) should undergo digital rectal examination.

Table 16: Examination – Rectal examination performed

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.11 Is there documented evidence that a rectal examination was performed? ** **%YES**	32	991/3134	14	333/2456	14	56/414	9	89/961

Denominators exclude those with data stated as being 'NO, but** consent could not be gained'

Rates for men were 52%, 28%, 14% and 14% respectively

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.11 Is there documented evidence that a rectal examination was performed? ** **%YES**	21	581/2764	11	205/1818	7	6/87	8	5/60

Denominators exclude those with data stated as being 'NO, but** consent could not be gained'

Rates for men were 53%, 30%, 13% and 3% respectively

Given the recommendation, available in draft at the time of the audit, it is interesting to see how few men reportedly have no documentation of an indication for DRE. The proportion of cases having a DRE as part of the examination is correspondingly low and potentially results in inappropriate management for some. Older men were more likely to be examined.

***NICE CG 97: 4.2.2:** At initial assessment, offer men with LUTS a urine dipstick test to detect blood, glucose, protein, leucocytes and nitrites.*
***NICE CG 40: Chapter 3. Assessment and investigation, urine testing, 3.5: Grade D, (GPP):** A urine dipstick should be undertaken in all women presenting with UI to detect the presence of blood, protein, leucocytes and nitrites in the urine.*

Table 17: Examination – Urinalysis

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.12 Is there documented evidence of urinalysis? **%YES**	76	2496	73	1909	71	380	74	847

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.12 Is there documented evidence of urinalysis? **%YES**	72	2019	74	1400	61	69	69	47

Urinalysis is performed for the majority of patients with UI and, largely this therefore conforms to current guidelines.

NICE CG 40: Chapter 3. Assessment and investigation, urine testing, 3.5: Grade D, (GPP): *Women with symptoms of UTI whose urine tests positive for both leucocytes and nitrites should have a mid stream urine specimen sent for culture and antibiotic sensitivities. An appropriate course should be prescribed dependent on the results.*

Table 18: Examination – mid stream urine specimen

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.13 Is there documented evidence of a mid stream specimen of urine being sent? ** **%YES**	59	1903/3218	38	970/2559	59	270/460	50	497/990

Denominators exclude those with data stated as being 'NO, but** patient is too distressed or too agitated'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.13 Is there documented evidence of a mid stream specimen of urine being sent? ** **%YES**	51	1424/2801	32	600/1857	54	54/100	53	32/60

Denominators exclude those with data stated as being 'NO, but** patient is too distressed or too agitated'

Approximately half of all cases, except those in primary care appeared to have a MSSU sent for analysis. The question unfortunately did not make it clear that a yes return was only to be made should the urinalysis be positive.

Consensus guidelines based upon recommendations from ***Good Practice in Continence Services (DH 2000).*** *Assessment of LUTS in men (EAU.)*
A focused examination should include evidence of:

- *examination of abdomen for palpable mass or bladder retention*
- *examination of external genitalia (men)*
- *evidence of rectal examination to exclude faecal loading*
- *assessment of manual dexterity*
- *neurological examination, if neurological pathology suspected.*

NICE CG 97: 4.5.2: *Offer men with LUTS having specialist assessment a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE).*
NICE CG 40: 3.2: History taking and examination, Grade 2(GPP):
At the initial clinical assessment, the woman's UI should be categorised as stress UI, mixed UI, or urge UI/OAB. Initial treatment should be started on this basis. In mixed UI, treatment should be directed towards the predominant symptom. The clinical assessment should seek to identify relevant predisposing and precipitating factors and other diagnoses that may require referral for additional investigation and treatment.

Table 19: Examination – Focused Examination

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.14 Is there documented evidence that a focused examination has been performed? **%YES**	69	2276	46	1192	50	268	21	238
2.14i If yes, who has performed the examination? **%YES**								
Geriatrician	20	456	7	84	3	7	3	7
GP	5	104	25	301	6	17	47	113
Gynaecologist (WOMEN)	35	476/1379	12	97/789	0.7	1/146	9	14/148
Nurse	16	364	55	659	11	30	46	109
Therapist	4	126	3	40	0.4	1	1	3
Hospital ward based doctor	40	902	13	157	84	224	11	26
Urologist	30	693	18	211	6	17	16	38
Other	0.6	14	0.8	9	0.7	2	1	3

Table 19: Examination – Focused Examination

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.14 Is there documented evidence that a focused examination has been performed? **%YES**	84	2376	66	1233	33	38	31	21
2.14i If yes, who has performed the examination? **%YES**								
Geriatrician	4	91	0.2	3	-	0	5	1
GP	6	152	21	259	8	3	33	7
Gynaecologist (WOMEN)	58	1115/1933	16	157/971	13	3/24	-	0/13
Nurse	16	378	64	794	5	2	71	15
Therapist	5	129	6	68	-	0	14	3
Hospital ward based doctor	15	368	5	67	74	28	19	4
Urologist	35	825	14	177	16	6	14	3
Other	0.5	13	1	14	3	1	-	0

A lower proportion of older people underwent a focused examination for their UI problem.

Gynaecologists played a lesser role in the examination of older women in hospitals and nurses played a greater role for all in primary care.

NICE CG40: p25: *Abdominal examination can detect a significantly enlarged bladder or palpable pelvic mass. A palpable bladder may indicate the presence of chronic urinary retention. Palpation may detect a volume of 300 ml or more. Urinary incontinence may occur in association with urinary retention (often called overflow incontinence). Pelvic assessment is important and should include vaginal examination, and possibly also rectal examination if clinically indicated. Vaginal examination can assess POP and identify atrophic changes, infection and excoriation. Uterine and ovarian enlargement may be determined by bimanual examination. When rectal examination is undertaken, it is used to further evaluate posterior vaginal wall prolapse and, where indicated by a history of constipation, prolapse or faecal incontinence.*
NICE CG97: 4.5.2: *Offer men with LUTS having specialist assessment a physical examination guided by urological symptoms and other medical conditions, an examination of the abdomen and external genitalia, and a digital rectal examination (DRE).*
NICE CG 40: Chapter 3. Assessment and investigation, assessment of residual volume, 3.6: Grade D, (GPP): *Women are found to have a palpable bladder on bimanual or abdominal examination after voiding should be referred to a specialist.*
NICE CG 40: Chapter 3. Assessment and investigation, pelvic floor muscle assessment, 3.3: Grade D, (GPP): *Routine digital assessment of pelvic floor muscle contraction should be undertaken before the use of supervised pelvic floor muscle training.*

Note that responses to Q2.15 were given independently of whether or not there was a focused examination (Q2.14).

Table 20: Examination – Focused Examination

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.15 Is there documented evidence of the following? **%YES**								
2.15i Examination of the abdomen for palpable mass or bladder retention	80	2626	30	773	64	343	20	232
2.15ii Examination to assess pelvic floor dysfunction	26	847	17	447	6	34	5	52
2.15iii Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy	42	848	29	523	11	31	11	91
2.15iv Rectal examination to exclude faecal loading/prostate size**	31	974/3130	14	346/2483	13	56/427	10	93/976

Denominators exclude those with data stated as being 'NO, but** consent could not be gained'

Table 20: Examination – Focused Examination

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.15 Is there documented evidence of the following? **%YES**								
2.15i Examination of the abdomen for palpable mass or bladder retention	76	2137	33	619	43	49	22	15
2.15ii Examination to assess pelvic floor dysfunction	58	1642	39	740	9	10	3	2
2.15iii Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy	73	1643	51	739	10	7	3	1
2.15iv Rectal examination to exclude faecal loading/prostate size**	22	602/2762	11	200/1816	7	7/95	5	3/59

Denominators exclude those with data stated as being 'NO, but** consent could not be gained'

Generally, elements of the examination are done most consistently in the hospital setting. A lower proportion of older people than younger people appear to have elements of the examination other than abdominal palpation. The proportion of people undergoing rectal examination is poor. Given the current political push to treat more people in primary care, it appears that the requisite practice is not up to current standard for many.

NICE CG 40: Grade D, (GPP): *Women with UI who have a symptomatic prolapse that is visible at or below the vaginal introitus should be referred to a specialist. There should be documentation of this finding and an indication that, should the woman want it, a referral was made.*

Table 21: Examination – Focused Examination

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
2.16 Is there documented evidence that a woman with a symptomatic prolapse extending to the introitus was referred for a specialist opinion? (WOMEN)** **%YES**	30	217/731	11	99/931	6	7/123	5	17/322

**Denominators exclude those with data stated as being ''No prolapse present' or 'No, but consent could not be gained'

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
2.16 Is there documented evidence that a woman with a symptomatic prolapse extending to the introitus was referred for a specialist opinion? (WOMEN)** **%YES**	49	329/678	17	103/597	5	2/37	-	0/7

**Denominators exclude those with data stated as being ''No prolapse present' or 'No, but consent could not be gained'

NICE CG 97 made recommendations regarding investigations which appeared unnecessary in the initial assessment.

NICE CG97: 4.8.2*: At initial assessment, offer men with LUTS a serum creatinine test (plus estimated glomerular filtration rate [eGFR] calculation) only if you suspect renal impairment (for example, the man has a palpable bladder, nocturnal enuresis, recurrent urinary tract infections or a history of renal stones).*
NICE CG97: 4.12.2: *Do not routinely offer cystoscopy to men with uncomplicated LUTS (that is, without evidence of bladder abnormality) at initial assessment.*
NICE CG97: 4.13.2: *Do not routinely offer imaging of the upper urinary tract to men with uncomplicated LUTS at initial assessment.*
NICE CG97: 3.2.1: *Do not routinely offer flow-rate measurement to men with LUTS at initial assessment. Do not routinely offer a post void residual volume measurement to men with LUTS at initial assessment.*

The NACC working party felt that these recommendations were equally applicable to women, and directed that responses should be sought from all clinical cases. They form negative quality indicators where performed.

Table 22: Investigations – Initial Assessment

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.17 Is there documented evidence of: **%YES**								
• Urea & Electrolytes	75	2469	29	764	76	409	36	413
• GFR (without indication of renal impairment)	35	1145	9	240	16	85	2	22
• Cystoscopy	17	571	4	109	0.9	5	2	23
• Abdominal Ultrasound	19	627	6	144	4	23	6	74
• Abdominal X-ray	11	345	2	51	7	40	2	23
• Flow Rate	18	595	5	136	2	12	0.9	10
• Post void residual volume	36	1179	33	852	3	16	3	33
• None of the above	9	289	43	1126	22	120	62	707

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.17 Is there documented evidence of: **%YES**								
• Urea & Electrolytes	46	1283	20	379	61	69	50	34
• GFR (without indication of renal impairment)	20	552	6	112	8	9	1	1
• Cystoscopy	24	682	5	96	2	2	-	0
• Abdominal Ultrasound	23	649	8	145	6	7	4	3
• Abdominal X-ray	7	199	1	24	3	3	3	2
• Flow Rate	38	1069	7	127	3	3	1	1
• Post void residual volume	51	140	47	875	0.9	1	24	16
• None of the above	19	525	36	678	36	41	46	31

As can be seen, a high proportion of older people have investigations performed at the initial assessment. The necessity of these should be reviewed in the light of guidelines.

NICE CG 40: Chapter 3. Assessment and investigation, assessment of residual volume, 3.6:
Grade B (DS): *The measurement of post-void residual volume (PVR) by bladder scan or catheterisation should be performed in women with symptoms suggestive of voiding dysfunction or urinary tract infection (UTI).*
3.6: Grade D (GPP): *A bladder scan should be used in preference to catheterisation on the grounds of acceptability and lower incidence of adverse effects.*
The presence of a significant post voiding residual volume of urine will have an influence on management of the bladder problem. Younger women only where clinically indicated; older women (good practise guideline only).

Table 23: Investigations – Initial PVRD

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
2.18 Is there documented evidence of measurement of post-void residual volume (PVR) using ultrasound or catheterisation? (WOMEN) ** **%YES**	40	773/1954	38	646/1713	4	10/237	5	34/717

**Denominators exclude those with data stated as being 'No, but consent could not be gained'

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
2.18 Is there documented evidence of measurement of post-void residual volume (PVR) using ultrasound or catheterisation? (WOMEN) ** **%YES**	56	1246/2243	55	777/1418	9	6/66	13	4/32

**Denominators exclude those with data stated as being 'No, but consent could not be gained'

Given the prevalence of voiding symptoms in women, it is likely that this investigation is overutilised, to no clinical benefit. Likewise, where voiding symptoms are commonest, in older women, fewer undergo the investigation.

NICE CG 40: Chapter 3. Assessment and intervention, imaging, 3.14: Grade D: *Imaging (magnetic resonance imaging, computed tomography, x-ray) is not recommended for the routine assessment of women with UI. Ultrasound is not recommended other than for the assessment of residual urine volume. Imaging of the renal tract and bladder is only recommended where there is reason to suspect renal impairment from the history (renal stones, recurrent urinary infection, haematuria).*
NICE CG 40: Chapter 3. Assessment and investigation, pad testing, 3.10: Grade D: *Pad tests are not recommended for the routine assessment in women with urinary incontinence.*
It is likely to be only recommended for men where there is a clinical need to quantify urine loss as part of a specialised assessment.

Table 24: Investigations – Pad test

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.19 Is there documented evidence of the use of a pad test for routine assessment? **%YES**	4	139	3	82	13	69	31	353

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.19 Is there documented evidence of the use of a pad test for routine assessment? **%YES**	4	122	3	57	11	12	26	18

This test is used appropriately, its use in routine practice is not recommended. The use in care home residents should be questioned.

Table 25: Investigations – Specialised Assessment (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
2.20 Is there documented evidence of: **%YES**								
• Cystocopy for men with chronic retention, pain or recurrent urinary infection	24	300	10	86	2	6	5	17
• Flow Rate	22	274	13	111	2	5	3	9
• Post void residual volume	42	532	37	305	3	7	5	16
• None of the above	49	620	57	469	94	230	91	297

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
2.20 Is there documented evidence of: **%YES**								
• Cystocopy for men with chronic retention, pain or recurrent urinary infection	34	192	11	49	7	3	-	0
• Flow Rate	43	239	17	74	7	3	3	1
• Post void residual volume	54	302	48	213	-	0	18	6
• None of the above	31	174	43	192	87	39	79	27

Relatively few people appear to receive a cystoscopic examination when indicated. 24% of patients <65 underwent cystoscopy at initial investigation The distribution of investigations at specialist assessment appears low overall and a greater proportion of older than younger men received no investigations.

NICE CG 40: Chapter 3. Assessment and intervention, imaging, 3.14: Grade D: *Imaging (magnetic resonance imaging, computed tomography, x-ray) is not recommended for the routine assessment of women with UI. Ultrasound is not recommended other than for the assessment of residual urine volume. Imaging of the renal tract and bladder is only recommended where there is reason to suspect renal impairment from the history (renal stones, recurrent urinary infection, haematuria).*

Table 26: Investigations – Specialised Assessment

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.21 Is there documented use of routine imaging (CT / MRI / X-ray / ultrasound) for routine assessment?** **%YES**	29	950	10	272	14	75	5	37/751

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.21 Is there documented use of routine imaging (CT / MRI / X-ray / ultrasound) for routine assessment?** **%YES**	30	839	12	226	13	15	2	1/43

****** Denominators excludes care home residents with 'Records not available'

Rates for women were 27%, 11%, 15% and 0% respectively

Again, this is a negative indicator, where these investigations should not be used for routine assessment. In hospitals there appears to be considerable routine use, less in the other settings. A relatively high proportion of women in hospitals underwent investigation not recommended by NICE as part of their initial assessment. This was consistent, regardless of age. The NICE guideline for women also addressed the PVRV.

NICE CG 40: Chapter 3. Assessment and investigations, other tests for urethral competence, 3.12: Grade D: *Q-tip, Bonney, Marshall and Fluid-Bridge tests are not recommended in the assessment of women with UI.*
NICE CG 40: Chapter 3. Assessment and investigations, cystoscopy, 3.13: Grade D, (GPP): *Cystoscopy is not recommended in the initial assessment of women with UI alone.*
These detailed investigations are not recommended for the initial investigation of urinary incontinence in women.

Table 27: Investigations – Specialised Assessment (Women)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
2.22 In routine assessment is there documented evidence of the use of ** **%YES**								
Q-tip test	0.6	13	0.4	7	-	0	-	0/500
Bonney's test	0.7	15	0.2	3	-	0	-	0/499
Fluid bridge test	0.2	4	0.2	3	-	0	-	0/498
Cystoscopy	11	225	2	32	-	0	1	7/502

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
2.22 In routine assessment is there documented evidence of the use of ** **%YES**								
Q-tip test	0.5	12	1	17	-	0	-	0/22
Bonney's test	1	25	0.1	2	-	0	-	0/22
Fluid bridge test	0.1	3	0.1	2	-	0	-	0/22
Cystoscopy	19	431	3	42	-	0	4	1/23

****** Denominators excludes care home residents with 'Records not available'

These tests are not recommended for use in NICE CG40. Correspondingly, their use is low in all settings. The single exception is the likely over use of cystoscopy at initial assessment.

Table 28: Investigations – Urodynamic Testing (Cystometry)

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.23 Did the patient have conservative treatment? ** **%YES**	59	1926	53	1386	12	64	11	82/774

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.23 Did the patient have conservative treatment? ** **%YES**	66	1867	64	1195	8	9	10	5/52

****** Denominators excludes care home residents with 'Records not available'

At best, 2/3 of acute hospital cases underwent conservative treatment for their incontinence. Slightly lower proportions of cases underwent conservative treatment in primary care and fewer in the older groups.

NICE CG 40: Chapter 3. Assessment and investigations, urodynamic testing, 3.11: Grade D: *The use of multi-channel cystometry ambulatory urodynamics or videourodynamics is not recommended before starting conservative treatment.*
Grade D: *For the small group of women with a clearly defined clinical diagnosis of pure stress urinary incontinence in women, the use of multi-channel cystometry is not recommended.*
The use of multi-channel cystometry is not recommended prior to wither conservative treatment in women or prior to primary surgery for stress urinary incontinence in women. Cystometry is likely to be only recommended for men pursuing a surgical treatment for their LUTS.
NICE CG 97: 3.2.1: *Consider offering multichannel cystometry to men with LUTS having specialist assessment if they are considering surgery.*

Table 29: Investigations – Urodynamic Testing (Cystometry)

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.24 Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment? ** **%YES**	13	246/1926	5	65/1386	2	1/64	2	1/55

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.24 Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment? ** **%YES**	24	452/1867	7	89/1195	11	1/9	-	0/4

****** Denominators excludes care home residents with 'Records not available'

This is a negative quality indicator, cystometry prior to conservative therapy is not recommended in the NICE guideline for women. A quarter of younger women in hospitals appear to undergo this investigation; one eighth of older women.

Table 30: Investigations – surgery

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.25 Did the patient have surgery or is it documented that they are considering surgery? ** **%YES**	22	732	9	230	2	13	2	19/829

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.25 Did the patient have surgery or is it documented that they are considering surgery? ** **%YES**	44	1240	12	223	4	4	2	1/51

****** Denominators excludes care home residents with 'Records not available'

NICE CG 40: Chapter 3. Assessment and investigations, 3.11: Grade D (GPP): *Multi-channel filling and voiding cystometry is recommended in women before surgery for UI if:*

- *there is clinical suspicion of detrusor overactivity, or*
- *there has been previous surgery for stress urinary incontinence or anterior compartment prolapse, or*
- *there are symptoms suggestive of voiding dysfunction.*

Ambulatory urodynamics or video-urodynamics may also be considered in these circumstances.
Monosymptomatic stress urinary incontinence is *leakage on effort in the absence of urinary urgency, urinary frequency, urgency incontinence, voiding symptoms*

Table 31: Investigations – (Cystometry) (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
2.26 For women with monosymptomatic stress urinary incontinence, is there documented evidence of the use of multi-channel cystometry **prior to** surgery? ** **%YES**	18	144/797	4	42/1114	0.5	1/184	0.5	2/391

****** Denominators excludes those who 'Did not have monosymptomatic stress urinary incontinence' and care home residents with 'Records not available'

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
2.26 For women with monosymptomatic stress urinary incontinence, is there documented evidence of the use of multi-channel cystometry **prior to** surgery? ** **%YES**	47	490/1032	8	67/841	2	1/50	-	0/8

****** Denominators excludes those who 'Did not have monosymptomatic stress urinary incontinence' and care home residents with 'Records not available'

NICE has recommended that cystometry not be undertaken for this category of woman. There has been much controversy about this given the nature of the evidence upon NICE relied to make its recommendation and there have been several publications which have shown that it is normal practice for all women to undergo cystometry prior to surgery. Given this then, it is surprising to see that only 47% of younger women and an even lower 18% of older women in the acute hospitals had the test.

Table 32: Investigations –Cystometry

65+	Acute (Hospital) N=305		Primary Care N=116		Mental Health N=10		Care Home N=11	
	%	N	%	N	%	N	%	N
2.27 Is there documented evidence of multi channel cystometry for men considering surgery for their lower urinary tract symptoms (LUTS)? ** **%YES**	35	107	15	17	-	0	-	0/4

****** Denominators excludes 'care home residents with 'Records not available'

<65	Acute (Hospital) N=146		Primary Care N=50		Mental Health N=1		Care Home N=0	
	%	N	%	N	%	N	%	N
2.27 Is there documented evidence of multi channel cystometry for men considering surgery for their lower urinary tract symptoms (LUTS)? ** **%YES**	42	61	18	9	-	0/1	-	-

****** Denominators excludes 'care home residents with 'Records not available'

The proportion of men offered multichannel cystometry prior to surgery is low.

NICE CG 40: Key recommendation. Chapter 3. Initial Assessment and investigation, Grade D, (GPP): *At the initial clinical assessment the women's urinary incontinence (UI) should be categorised as stress UI, mixed UI, or urge UI/ overactive bladder (OAB).*
There should be documented evidence of a clear identification of the type/cause of urinary incontinence. Diagnosis allows the formulation of a management plan for the patient.

Table 33: Investigations – Diagnosis

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
2.28 Is there documented evidence of a clear identification of the type/cause of urinary incontinence? **%YES**	58	1916	67	1739	41	223	53	605

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
2.28 Is there documented evidence of a clear identification of the type/cause of urinary incontinence? **%YES**	82	2301	82	1533	40	46	54	37

The majority of cases in hospitals and primary care had a clear diagnosis written down. In only half or fewer cases in mental health care or care homes did this occur. Fewer older people had a clear diagnosis written down in hospitals and primary care.

Management

This includes fluid management, bladder retraining, caffeine restriction, avoidance of precipitating factors, pelvic floor muscle therapy, with or without biofeedback electrical stimulation, tibial afferent nerve stimulation and drug therapy.

NICE CG 40: Chapter 4. 4.1: Lifestyle interventions.
Grade D: *A trial of caffeine reduction is recommended in the treatment for women with overactive bladder (OAB)*
Grade D, (GPP): *Consider advising modification of high or low fluid intake for the treatment of women with UI or OAB.*
Grade D: *Women with UI or OAB who have a body mass index greater than 30 should be advised to lose weight.*
NICE CG 40: Chapter 4. 4.2: Physical therapies.
Grade A: *A trial of supervised pelvic floor muscle training of at least 3 months duration should be offered as first line treatment to women with stress or mixed urinary continence (UI).*
Grade A: *Pelvic floor muscle training programmes should comprise of at least eight contractions performed 3 times per day.*
Grade D (GPP): *If pelvic floor muscle training is beneficial, an exercise programme should be maintained.*
Grade A: *Perineometry or pelvic floor electromyography as biofeedback should not be used as a routine part of pelvic floor muscle training.*
Grade D: *Electrical stimulation should not routinely be used in the treatment of women with OAB.*
Grade A: *Electrical stimulation should not routinely be used in combination with pelvic floor training.*
Grade D (GPP): *Electrical stimulation and/or biofeedback should be considered in women who cannot actively contract pelvic floor muscles in order to aid motivation and adherence to therapy.*
NICE CG 40: Chapter 4. 4.3: Behavioural therapies.
Grade A: *Bladder training lasting for a minimum of 6 weeks should be offered as first line treatment to women with urge or mixed UI*
Grade A: *If women do not achieve satisfactory benefit from bladder training programmes, the combination of an antimuscarinic agent with bladder training should be considered if frequency is a troublesome symptom.*
Grade A: *In women with UI who also have cognitive impairment, prompted and timed voiding toileting programmes, the combination of an antimuscarinic agent with bladder training should be considered if frequency is a troublesome symptom.*
NICE CG97: **3.2.2: Recommendations on conservative management.**
Explain to men with post micturition dribble how to perform urethral milking.
Offer men with storage LUTS suggestive of overactive bladder (OAB) supervised bladder training, advice on fluid intake, lifestyle advice and, if needed, containment products.
Inform men with LUTS and proven bladder outlet obstruction that bladder training is less effective than surgery.
Offer supervised pelvic floor muscle training to men with stress urinary incontinence caused by prostatectomy. Advise them to continue the exercises for at least 3 months before considering other options.
Refer for specialist assessment men with stress urinary incontinence.
Do not offer penile clamps to men with storage LUTS (particularly urinary incontinence).
Offer external collecting devices (for example, sheath appliances, pubic pressure urinals) for managing storage LUTS (particularly urinary incontinence) in men before considering indwelling catheterisation.
Offer intermittent bladder catheterisation before indwelling urethral or suprapubic catheterisation to men with voiding LUTS that cannot be corrected by less invasive measures.
See Q 3.8 to 3.10 for drug therapies.

Table 34: Management – Treatment required

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
3.1 Did the patient require treatment? **%YES**	84	2763	84	2203	54	293	36	413

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
3.1 Did the patient require treatment? **%YES**	92	2578	92	1725	54	61	43	29

In hospitals and primary care, the majority of cases were reported to require treatment. This proportion was lowest for care homes and may reflect the fact that many had been assessed and managed prior to entry to the home.

Table 35: Management – Treatment plan

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
3.2 Did the patient have a treatment **%YES** plan?	64	2107	71	1844	54	291	46	527

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
3.2 Did the patient have a treatment **%YES** plan?	81	2267	80	1500	52	59	53	36

A lower proportion of older people in both hospitals and primary care had a documented plan.

Table 36: Management – Treatments

Denominators for the next table are those who either required or who received treatment

65+	Acute (Hospital) N=2827		Primary Care N=2324		Mental Health N=341		Care Home N=532	
	%	N	%	N	%	N	%	N
3.3 Which of the following methods of treatment have been used or are planned? **%YES**								
Lifestyle modification	30	858	52	1202	26	90	39	207
Behavioural modification	21	599	32	745	25	84	30	162
Bladder training regimes (supervised)	22	608	30	700	15	51	29	155
Containment	56	1580	69	1604	60	203	75	400
Electrical stimulation (incl. afferent nerve stimulation)	2	43	3	66	0.6	2	5	24
Management of faecal impaction	14	402	9	218	17	58	39	209
Topical oestrogen treatment (WOMEN)	11	193/1744	9	142/1579	2	3/194	8	32/378
Pelvic floor training (supervised and of minimum three months duration)	20	563	22	522	2	8	6	31
Review of medication	40	1128	36	829	43	147	68	364
Toileting schedules	18	513	30	687	56	192	80	426
Treatment of co-morbidities	34	962	19	442	26	90	33	175
Treatment of acute urinary tract infection	33	935	20	461	36	122	52	279
Urethral milking (MEN)	2	26/1083	4	32/745	0.7	1/147	6	9/154
Other*	15	433	6	139	4	15	2	12

*Others (Acute Hospitals) – Surgery 173, ISC 28, Alternative & complementary treatment 1, Drugs 74, Antibiotics 6, Botulinum toxin 27, Catheter, indwelling 94, Cystoscopy 10, Pessaries 30, Dilation for stricture 5

*Others (Primary Care) – Surgery 23, ISC 23, Drugs 39, Antibiotics 7, Botulinum toxin 2, Catheter, indwelling 37, Cystoscopy 1, Pessaries 7, Dilation for stricture 3

*Others (Mental Health) – Surgery 1, ISC 1, Drugs 5, Antibiotics 2, Catheter, indwelling 6

*Others (Care Homes) –Antibiotics 1, Catheter, indwelling 11

Table 36: Management – Treatments

Denominators for the next table are those who either required or who received treatment

<65	Acute (Hospital) N=2621		Primary Care N=1758		Mental Health N=67		Care Home N=38	
	%	N	%	N	%	N	%	N
3.3 Which of the following methods of treatment have been used or are planned? **%YES**								
Lifestyle modification	49	1273	68	1199	45	30	66	25
Behavioural modification	34	903	43	752	37	25	58	22
Bladder training regimes (supervised)	36	943	40	706	24	16	45	17
Containment	30	790	38	661	37	25	47	18
Electrical stimulation (incl. afferent nerve stimulation)	5	125	9	156	-	0	-	0
Management of faecal impaction	6	154	7	121	7	5	29	11
Topical oestrogen treatment (WOMEN)	7	156/2138	7	98/1353	2	1/46	5	1/20
Pelvic floor training (supervised and of minimum three months duration)	52	1363	49	868	9	6	5	2
Review of medication	33	866	35	618	40	27	68	26
Toileting schedules	16	408	21	375	42	28	66	25
Treatment of co-morbidities	17	443	14	239	25	17	39	15
Treatment of acute urinary tract infection	17	444	13	228	28	19	32	12
Urethral milking (MEN)	7	35/483	8	34/405	-	0/21	-	0/18
Other*	23	594	9	154	3	2	8	3

*Others (Acute Hospitals) – Surgery 325, ISC 43, Alternative & complementary treatment 2, Drugs 91, Antibiotics 4, Botulinum toxin 76, Catheter, indwelling 44, Cystoscopy 12, Pessaries 8, Dilation for stricture 14

*Others (Primary Care) – Surgery 25, ISC 69, Drugs 35, Antibiotics 5, Botulinum toxin 3, Catheter, indwelling 16, Cystoscopy 1, Dilation for stricture 2

*Others (Mental Health) – Antibiotics 2

*Others (Care Homes) –Alternative & complimentary treatment 1, Catheter, indwelling 2

Many of the "other" treatments could otherwise be classified elsewhere.

NICE CG 97: *Consider offering oral desmopressin to men with nocturnal polyuria if other medical causes have been excluded and they have not benefited from other treatments. Measure serum sodium 3 days after the first dose. If serum sodium is reduced to below the normal range, stop desmopressin treatment.*

Table 37: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.4 Is there documented evidence of the use of anti-muscarinic medication for the treatment of Over Active Bladder (OAB)? (MEN) ** **%YES**	27	160/583	24	115/483	6	5/89	4	7/163

****** Denominators excludes 'MEN who 'Did not have OAB'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.4 Is there documented evidence of the use of anti-muscarinic medication for the treatment of Over Active Bladder (OAB)? (MEN) ** **%YES**	51	122/241	36	92/254	14	4/29	-	0/16

****** Denominators excludes 'MEN who 'Did not have OAB'

Antimuscarinic medications for OAB in men appear to be underutilised, given that this is the prominent condition in older men, regardless of the presence of outflow tract obstruction.

Table 38: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.5 Is there documented evidence of a late afternoon diuretic for men with nocturnal polyuria? (MEN) ** **%YES**	3	14/530	6	22/395	-	0/92	6	10/168

****** Denominators excludes 'MEN who 'Did not have nocturnal polyuria'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.5 Is there documented evidence of a late afternoon diuretic for men with nocturnal polyuria? (MEN) ** **%YES**	0.6	1/173	0.6	1/170	3	1/29	-	0/16

****** Denominators excludes 'MEN who 'Did not have nocturnal polyuria'

Table 39: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.6 Is there documented use of DDAVP for men with nocturnal polyuria who have not benefited from other treatments? (MEN) ** **%YES**	1	5/504	0.3	1/366	-	0/87	0.6	1/163

****** Denominators excludes 'MEN who 'Did not have nocturnal polyuria'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.6 Is there documented use of DDAVP for men with nocturnal polyuria who have not benefited from other treatments? (MEN) ** **%YES**	4	7/173	0.6	1/170	7	2/29	-	0/16

****** Denominators excludes 'MEN who 'Did not have nocturnal polyuria'

Of those men with documented nocturnal polyuria, the use of a late afternoon diuretic is rare. Few men receive DDAVP; use is lower still in those 65+ (use outside current licensing).

Table 40: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.7 Is there documented use of alpha blockers for treatment of men with moderate to severe LUTS? ** (MEN) **%YES**	34	268/779	26	140/540	11	10/95	4	7/162

****** Denominators excludes 'MEN who 'Did not have moderate to severe LUTS'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.7 Is there documented use of alpha blockers for treatment of men with moderate to severe LUTS? ** (MEN) **%YES**	46	133/289	21	47/228	-	0/27	-	0/18

****** Denominators excludes 'MEN who 'Did not have moderate to severe LUTS'

The proportion of older men with moderate to severe symptoms receiving alpha blockers appears lower than one might expect given the prevalence of the symptoms in relation to increasing age.

Table 41: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.8 Is there documented use of 5-AR to men with larger prostates (30ml, or PSA >1.4ng/ml) considered to be at high risk of progression? ** (MEN) **%YES**	20	160/805	17	90/536	4	4/105	10	20/197

****** Denominators excludes 'MEN who 'Did not have large prostate (30ml) or PSA >1.4 ng/ml)'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.8 Is there documented use of 5-AR to men with larger prostates (30ml, or PSA >1.4ng/ml) considered to be at high risk of progression? ** (MEN) **%YES**	17	40/236	9	18/211	-	0/29	-	0/18

****** Denominators excludes 'MEN who 'Did not have large prostate (30ml) or PSA >1.4 ng/ml)'

Likewise, although age appropriate, use of these medications appears lower than one might expect.

Table 42: Pharmacological Interventions (MEN)

65+	Acute (Hospital) N=268		Primary Care N=140		Mental Health N=10		Care Home N=7	
	%	N	%	N	%	N	%	N
3.9 Is there evidence of an anticholinergic being added for men with persisting storage symptoms despite treatment with alpha blockers? ** (MEN)								
• Yes	28	59/211	25	27/110	11	1/9	-	0
• No	69	145/211	74	81/110	89	8/9	100	7
• Yes, but patient did not have alpha blocker first	3	7/211	2	2/110	-	0	-	0

****** Denominators excludes 'MEN who 'Did not have storage problems'

Denominators for this table are those MEN treated with alpha blockers (Q3.7=Yes)

<65	Acute (Hospital) N=268		Primary Care N=140		Mental Health N=10		Care Home N=7	
	%	N	%	N	%	N	%	N
3.9 Is there evidence of an anticholinergic being added for men with persisting storage symptoms despite treatment with alpha blockers? ** (MEN)								
• Yes	27	25/92	17	5/30	-	0	-	0
• No	63	58/92	73	22/30	-	0	-	0
• Yes, but patient did not have alpha blocker first	10	9/92	10	3/30	-	0	-	0

****** Denominators excludes 'MEN who 'Did not have storage problems'

These data reflect the current wariness of clinicians in prescribing antimuscarinics to men for fear of precipitating acute retention and the belief that LUTS in men are solely related to the outflow tract. There is little use of antimuscarinics in men as a sole treatment modality.
Additionally, some men may have been only part way down the treatment pathway and not yet had these additional medications considered.

NICE CG 40: Chapter 4. Conservative Management, drug therapies, 4.4: Grade A: *Immediate release non-proprietary oxybutynin should be offered to women with OAB or mixed UI as a first-line antimuscarinic drug treatment if bladder training has been ineffective. If immediate release non-proprietary oxybutynin is not well tolerated, darifenacin, solifenacin, tolterodine, trospium, or an extended release or transdermal formulation of oxybutynin should be considered as alternatives. Women should be counselled about the adverse effects of antimuscarinic drugs.*

Table 43: Pharmacological Interventions (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
3.10 Is there documented evidence that proprietary, immediate release oxybutynin was used as the first line treatment for women with a diagnosis of overactive bladder syndrome? ** (WOMEN)								
• Yes	15	206/1401	12	181/1468	2	5/209	6	41/637
• No	78	1098/1401	81	1192/1468	91	190/209	85	544/637
• No, but it is documented that medication tried previously or contraindication to prescription	7	97/1401	6	95/1468	7	14/209	8	52/637

****** Denominators excludes 'WOMEN who 'Did not have an overactive bladder'

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
3.10 Is there documented evidence that proprietary, immediate release oxybutynin was used as the first line treatment for women with a diagnosis of overactive bladder syndrome? ** (WOMEN)								
• Yes	21	320/1514	15	174/1140	6	3/51	12	3/25
• No	73	1098/1514	78	893/1140	86	44/51	80	20/25
• No, but it is documented that medication tried previously or contraindication to prescription	6	96/1514	6	73/1140	8	4/51	8	2/25

****** Denominators excludes 'WOMEN who 'Did not have an overactive bladder'

The guideline for use of generic immediate release oxybutynin as first line based upon cost minimalisation is widely ignored. There is little documentation of the reason for any contraindication to this drug.

NICE CG 40: Chapter 4. Conservative Management, drug therapies, 4.4: Grade A: *Duloxetine is not recommended as the first-line treatment for women with predominant stress UI. Duloxetine should not routinely be used as a second-line treatment for women with stress UI, although it may be offered as a second-line therapy if women prefer pharmacological to surgical treatment or are not suitable for surgical treatment. If duloxetine is prescribed, women should be counselled about its adverse effects.*

Table 44: Pharmacological Interventions (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
3.11 Is there documented evidence of the use of duloxetine for the treatment of women with Stress Urinary Incontinence? (WOMEN) ** **%YES**	4	53/1294	2	23/1366	2	4/181	2	13/619

****** Denominators excludes 'WOMEN who 'Did not have stress urinary incontinence''

Table 44: Pharmacological Interventions (WOMEN)

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
3.11 Is there documented evidence of the use of duloxetine for the treatment of women with Stress Urinary Incontinence? (WOMEN) ** **%YES**	10	177/1786	3	36/1181	4	2/50	6	1/18

****** Denominators excludes 'WOMEN who 'Did not have stress urinary incontinence''

In accordance with NICE guidelines, the use of duloxetine for women with SUI is minimal. We cannot ascertain whether this was routine use or second line therapy, or is current versus past therapy.

NICE CG 40: Chapter 4. Conservative Management, drug therapies, 4.4: Grade A:
Flavoxate, probantheline and imipramine should not be used for the treatment of UI or OAB in women.

Table 45: Pharmacological Interventions (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
3.12 Is there documented use of either probantheline, flavoxate or imipramine? (WOMEN) ** **%YES**	0.8	17	0.7	13	0.3	1	0.9	7

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
3.12 Is there documented use of either probantheline, flavoxate or imipramine? (WOMEN) ** **%YES**	1	25	1	14	1	1	-	0

These non recommended drugs are almost never used, in accordance with current guidelines.

NICE CG 97: 3.2.5: Recommendations on surgery for voiding symptoms

- *For men with voiding symptoms, offer surgery only if voiding symptoms are severe or if drug treatment and conservative management options have been unsuccessful or are not appropriate. Discuss the alternatives to and outcomes from surgery.*
- *If offering surgery for managing voiding LUTS presumed secondary to BPE, offer monopolar or bipolar transurethral resection of the prostate (TURP), monopolar transurethral vaporisation of the prostate (TUVP) or holmium laser enucleation of the prostate (HoLEP). Perform HoLEP at a centre specialising in the technique, or with mentorship arrangements in place.*
- *Offer transurethral incision of the prostate (TUIP) as an alternative to other types of surgery to men with a prostate estimated to be smaller than 30 g.*
- *Only offer open prostatectomy as an alternative to TURP, TUVP or HoLEP to men with prostates estimated to be larger than 80 g.*
- *If offering surgery for managing voiding LUTS presumed secondary to BPE, do not offer minimally invasive treatments (including transurethral needle ablation [TUNA], transurethral microwave thermotherapy [TUMT], high-intensity focused ultrasound [HIFU], transurethral ethanol ablation of the prostate [TEAP] and laser coagulation) as an alternative to TURP, TUVP or HoLEP.*
- *If offering surgery for managing voiding LUTS presumed secondary to BPE, only consider offering botulinum toxin injection into the prostate as part of a randomised controlled trial.*
- *If offering surgery for managing voiding LUTS presumed secondary to BPE, only consider offering laser vaporisation techniques, bipolar TUVP or monopolar or bipolar transurethral vaporisation resection of the prostate (TUVRP) as part of a randomised controlled trial that compares these techniques with TURP.*

Table 46: Surgery (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
3.13 For men, did the patient consider or have surgical intervention for LUTS secondary to benign prostatic enlargement? ** **%YES**	20	248	14	113	4	10	5	11/230
3.13i Is there documented evidence of the following procedures being carried out: **%YES**								
• Transurethral resection of the prostate (TURP)	73	180/248	71	80/113	50	5/10	64	7/11
• Holmium laser enucleation of the prostate (HOLEP	2	4/248	0.9	1/113	-	0/10	-	0/11
• Transurethral incision of the prostate (TUIP)	-	0/248	2	2/113	-	0/10	-	0/11
• Open prostatectomy (OP)	3	7/248	6	7/113	-	0/10	9	1/11
• Transurethral needle ablation (TUNA)	-	0/248	-	0/113	-	0/10	-	0/11
• Transurethral microwave thermotherapy (TUMT)	0.4	1/248	-	0/113	-	0/10	-	0/11
• High intensity focused ultrasound (HIFU)	-	0/248	-	0/113	-	0/10	-	0/11
• Transurethral ethanol ablation of the prostate (TEAP)	-	0/248	-	0/113	-	0/10	-	0/11
• Transurethral vaporization resection of the prostate (TURVP)	3	8/248	0.9	1/113	-	0/10	18	2/11
• None of the above	21	51/248	21	24/113	50	5/10	9	1/11

****** Denominators excludes care home residents with 'Records not available'

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
3.13 For men, did the patient consider or have surgical intervention for LUTS secondary to benign prostatic enlargement? ** **%YES**	14	78	7	32	-	0/45	-	0/26
3.13i Is there documented evidence of the following procedures being carried out: **%YES**								
• Transurethral resection of the prostate (TURP)	64	50/78	63	20/32				
• Holmium laser enucleation of the prostate (HOLEP	1	1/78	-	0/32				
• Transurethral incision of the prostate (TUIP)	3	2/78	6	2/32				
• Open prostatectomy (OP)	3	2/78	9	3/32				
• Transurethral needle ablation (TUNA)	-	0/78	-	0/32				
• Transurethral microwave thermotherapy (TUMT)	-	0/78	-	0/32				
• High intensity focused ultrasound (HIFU)	-	0/78	3	1/32				
• Transurethral ethanol ablation of the prostate (TEAP)	-	0/78	-	0/32				
• Transurethral vaporization resection of the prostate (TURVP)	4	3/78	-	0/32				
• None of the above	26	20/78	25	8/32				

****** Denominators excludes care home residents with 'Records not available'

Where surgery for voiding symptoms in men is performed, TURP dominates the list of procedures. There are some not recommended procedures performed which would bear examination.

Surgical treatment

NICE CG 40: 5.2: Procedures for stress urinary incontinence
Retropubic mid-urethral tape procedures using a 'bottom-up' approach with macroporous(type 1) polypropylene meshes are recommended as treatment options for stress UI if conservative management has failed.
Open colposuspension and autologous rectus fascial sling are the recommended alternatives when clinically appropriate.
Synthetic slings using a retropubic 'top-down' or a transobturator foramen approach are recommended as alternative treatment options for stress UI if conservative management has failed, provided women are made aware of the lack of long-term outcome data.
Synthetic slings using materials other than polypropylene that are not of a macroporous (type 1) construction are not recommended for the treatment of stress UI.
Intramural bulking agents (glutaraldehyde cross-linked collagen, silicone, carbon coated zirconium beads or hyaluronic acid/dextran copolymer) should be considered for the management of stress UI if conservative management has failed.
Women should be made aware that:

- *repeat injections may be required to achieve efficacy;*
- *efficacy diminishes with time;*
- *efficacy is inferior to that of retropubic suspension or sling.*

In view of the associated morbidity, the use of an artificial urinary sphincter should be considered for the management of stress UI in women only if previous surgery has failed. Life-long follow-up is recommended.
Laparoscopic colposuspension is not recommended as a routine procedure for the treatment of stress UI in women. The procedure should be performed only by an experienced laparoscopic surgeon working in a multidisciplinary team with expertise in the assessment and treatment of UI.

NICE CG 40: Chapter 5. Surgical Management, procedures for stress urinary incontinence, 5.2:
Grade A: *Anterior colporrhaphy, needle suspensions, paravaginal defect repair and Marshall- Marchetti – Krantz procedure are not recommended for the treatment of stress UI.*
5.2: Grade D: *Autologous fat and polytetrafluoroethylene (PTFE) used as intramural bulking agents are not recommended for the treatment of stress UI.*

Table 47: Surgery (WOMEN)

65+	Acute (Hospital) N=2011		Primary Care N=1786		Mental Health N=295		Care Home N=811	
	%	N	%	N	%	N	%	N
3.14 Did the Patient suffer from Stress Urinary Incontinence? **%YES**	32	648	35	620	10	30	23	188
3.14i For the treatment of SUI in women is there documented evidence of the use of **: **%YES**								
• Anterior colporrhaphy	5	32	1	6	3	1	0.5	1/94
• Needle suspension	0.5	3	-	0	-	0	-	0/94
• Paravaginal defect repair	2	16	0.3	2	-	0	-	0/94
• Marshall- Marchetti – Krantz procedure	0.2	1	-	0	-	0	-	0/94
• Autologous fat /PTFE injections	3	18	0.2	1	-	0	-	0/94
• Mid Urethral Tape	27	177	4	23	-	0	-	0/94
• Colpo suspension	5	34	2	11	-	0	1	2/95
• Autologous rectus fascial sligophoms	0.2	1	-	0	-	0	-	0/94

****** Denominators excludes care home residents with 'Records not available'

Table 47: Surgery (WOMEN)

<65	Acute (Hospital) N=2254		Primary Care N=1435		Mental Health N=69		Care Home N=34	
	%	N	%	N	%	N	%	N
3.14 Did the Patient suffer from Stress Urinary Incontinence? **%YES**	64	1442	53	759	17	12	12	4
3.14i For the treatment of SUI in women is there documented evidence of the use of **: **%YES**								
• Anterior colporrhaphy	5	75	1	9	-	0	-	0/3
• Needle suspension	0.1	2	0.3	2	-	0	-	0/3
• Paravaginal defect repair	2	31	0.3	2	-	0	-	0/3
• Marshall- Marchetti – Krantz procedure	0.1	2	0.5	4	8	1	-	0/3
• Autologous fat /PTFE injections	1	19	0.5	4	-	0	-	0/3
• Mid Urethral Tape	41	597	7	51	8	1	-	0/3
• Colpo suspension	6	82	2	13	-	12	-	0/3
• Autologous rectus fascial sligophoms	2	31	0.3	2	-	0	-	0/3

****** Denominators excludes care home residents with 'Records not available'

For women with stress incontinence the mid urethral tapes and colposuspension dominate. There is some use of anterior repair in both younger and older women which is not recommended as a treatment for SUI. The proportion of women having surgery in care homes and mental health care reflects the nature of the population in that setting. The lower proportion of older women undergoing surgery should be adjusted for case mix, but at face value, this seems lower than might be expected, given the nature of the condition.

Containment

NICE CG 40: Chapter 4. Conservative Management, non therapeutic interventions, 4.5: Grade D (GPP): *Bladder catheterisation (intermittent or indwelling urethral or suprapubic) should be considered for women in whom persistent urinary retention is causing incontinence, symptomatic infections or renal dysfunction, and in whom this cannot otherwise be corrected. Healthcare professionals should be aware, and explain to women, that the use of indwelling catheters in urge UI may not result in continence.*
Catheterisation should only be a long term solution to incontinence when other management methods have failed, are impractical or this is the result of informed choice by a competent patient. An indication for catheterisation should be entered into the clinical record.
4.5.3: Recommendation for products to prevent leakage Grade D (GPP)
Intravaginal and intraurethral devices are not recommended for the routine management of UI in women. Women should not be advised to consider such devices other than for occasional use when necessary to prevent leakage, for example during physical exercise.
4.5: Non-therapeutic interventions Grade D (GPP)
Absorbent products, hand-held urinals and toileting aids should not be considered as a treatment for UI. They should be used only as:

- *a coping strategy pending definitive treatment;*
- *an adjunct to other ongoing therapy;*
- *long-term management of UI only after treatment options have been explored.*

NICE CG 97: 3.2.2: *Offer men with storage LUTS (particularly urinary incontinence) temporary containment products (for example, pads or collecting devices) to achieve social continence until a diagnosis and management plan have been discussed.*
Provide men with storage LUTS (particularly incontinence) containment products at point of need, and advice about relevant support groups. Offer a choice of containment products to manage storage LUTS (particularly urinary incontinence) based on individual circumstances and in consultation with the man. Consider offering long-term indwelling urethral catheterisation to men with LUTS: for whom medical management has failed and surgery is not appropriate and who are unable to manage intermittent self-catheterisation or with skin wounds, pressure ulcers or irritation that are being contaminated by urine or who are distressed by bed and clothing changes.
If offering long-term indwelling catheterisation, discuss the practicalities, benefits and risks with the man and, if appropriate, his carer.
Explain to men that indwelling catheters for urgency incontinence may not result in continence or the relief of recurrent infections.
Consider permanent use of containment products for men with storage LUTS (particularly urinary incontinence) only after assessment and exclusion of other methods of management.

Table 48: Containment

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
3.15 Which of the following methods of containment have been used or are planned for treatment? **%YES**								
• Body worn pads (disposable)	48	1570	60	1559	72	390	76	869
• Body worn pads (re-usable)	1	34	2	54	2	9	1	15
• All-in-one disposable	2	76	4	98	13	69	19	213
• All-in-one (re-usable)	0.2	5	0.7	18	1	8	1	14
• Reusable products (pants)	3	110	4	106	4	23	16	181
• Bed protection	7	226	4	108	19	103	13	143
• Indwelling catheter	26	844	7	190	4	24	10	118
• Intermittent catheterisation	6	213	3	79	0.4	2	1	11
• Devices	3	90	3	88	0.2	1	1	16
• Penile Clamps (MEN)	<0.1	1/1271	<0.1	1/826	-	0/244	-	0/328
• Containment not part of care plan	11	346	12	307	5	29	1	15
• Not documented	18	577	14	364	10	54	1	11
• Other	1	43	1	23	0.2	1	0.6	7

Table 48: Containment

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
3.15 Which of the following methods of containment have been used or are planned for treatment? **%YES**								
• Body worn pads (disposable)	30	841	32	608	49	56	78	53
• Body worn pads (re-usable)	0.7	20	1	27	2	2	-	0
• All-in-one disposable	1	34	2	32	18	20	13	9
• All-in-one (re-usable)	<0.1	2	0.2	4	-	0	-	0
• Reusable products (pants)	0.5	13	2	29	3	3	3	2
• Bed protection	2	44	3	54	26	30	21	14
• Indwelling catheter	10	283	4	83	3	3	26	18
• Intermittent catheterisation	9	255	8	154	2	2	4	3
• Devices	2	46	4	71	4	5	-	0
• Penile Clamps (MEN)	0.2	1/559	0.4	2/445	-	0/45	-	0/34
• Containment not part of care plan	24	664	34	647	16	18	3	2
• Not documented	31	860	20	374	15	17	-	0
• Other	0.5	14	0.5	9	-	0	1	1

The proportionate use of disposable pads increases in the older cohort and across the sectors, with care homes using these most frequently. Catheter use in primary care reflects what is known of community prevalence. A proportion of catheters used in hospitals is short term, for retention, rather than as management for incontinence.

Table 49: Indication for indwelling catheterisation

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
3.16 Is there documented evidence of the indication for indwelling catheterisation as a form of management? **%YES**	26	866	9	228	6	30	12	136

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
3.16 Is there documented evidence of the indication for indwelling catheterisation as a form of management? **%YES**	13	359	6	105	4	5	32	22

Few people have a documented indication for catheterisation. This information may have been unavailable to the auditors but this appears to be below the standard of what might be expected.

Table 50: maintenance products on discharge

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
3.17 Is there documented evidence of the arrangement for provision of maintenance products on discharge from hospital? ** **%YES**	29	604/2093	23	195/840	35	87/246	15	44/298
• Patient to buy products	3	20	9	18	2	2	11	5
• Limited supply from hospital followed by own supply	9	52	10	19	14	12	2	1
• Limited supply from hospital followed by NHS supply	76	460	63	123	70	61	39	17
• No supply from hospital with an arrangement for NHS supply	12	72	18	35	14	12	48	21

**Denominators exclude those with data stated as being 'Not applicable'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
3.17 Is there documented evidence of the arrangement for provision of maintenance products on discharge from hospital? ** **%YES**	16	195/1215	10	40/421	22	11/49	36	4/11
• Patient to buy products	11	22	8	3	18	2	-	0
• Limited supply from hospital followed by own supply	9	17	5	2	-	0	25	1
• Limited supply from hospital followed by NHS supply	69	134	78	31	45	5	25	1
• No supply from hospital with an arrangement for NHS supply	11	22	10	4	36	4	50	2

**Denominators exclude those with data stated as being 'Not applicable'

This table only relates to those with a recent hospitalisation, however, the current arrangements for continuing supply of pads appears to rest firmly with the NHS. There is though, limited documentation of any arrangement across the sectors and further clarification may well be required.

Essence of Care (2001): *All patients with urinary incontinence should have a personalised and documented care plan outlining the goals of care and the implementation and effectiveness of this plan should be regularly reviewed.*
Good Practice in Continence Services (DH 2000).

NICE CG 97: 3.2.4: Recommendations on review
Discuss active surveillance (reassurance and lifestyle advice without immediate treatment and with regular follow-up) or active intervention (conservative management, drug treatment or surgery) for:
• men with mild or moderate bothersome LUTS

Table 51: Care Plan & Review

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
4.1 Does the patient have a documented continence care plan? **%YES**	42	1379	68	1764	63	340	99	1131
4.1i when was the patient's care plan last reviewed?								
• Less than 6 months	76	1043	63	1113	91	311	92	1040
• 6-8 months	9	123	15	261	3	11	5	53
• 9-11 months	2	28	7	121	2	6	1	13
• 12 months or more	3	43	8	138	2	6	2	19
• No documentation of reassessment	10	142	7	131	2	6	0.5	6

Table 51: Care Plan & Review

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
4.1 Does the patient have a documented continence care plan? **%YES**	54	1513	74	1384	64	73	100	68
4.1i when was the patient's care plan last reviewed?								
• Less than 6 months	78	1182	73	1010	88	64	96	65
• 6-8 months	9	140	12	161	3	2	1	1
• 9-11 months	4	61	5	73	1	1	-	0
• 12 months or more	3	46	7	90	3	2	1	1
• No documentation of reassessment	6	84	4	50	5	4	1	1

Care plans are still underused in acute and mental health sites. Care plans appear to be almost universally used in Barchester care homes.

NICE CG 97: *men whose LUTS fail to respond to drug treatment.*
Review men taking drug treatments to assess symptoms, the effect of the drugs on the patient's quality of life and to ask about any adverse effects from treatment.
Review men taking alpha blockers at 4-6 weeks and then every 6-12 months.
Review men taking 5–alpha reductase inhibitors at 3-6 months and then every 6-12 months.
Review men taking anticholinergics every 4-6 weeks until symptoms are stable, and then every 6-12 months.

Table 52: Review on alpha blockers (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
4.2 Is there evidence of review for men on alpha blockers at: ** **%YES**								
• 4-6 weeks Not yet relevant	24	104/439	28	94/337	47	35/75	35	36/103
• 4-6 weeks (if relevant)	39	129/335	34	82/243	23	9/40	9	6/67
• 6-12 months Not yet relevant	37	175/476	41	149/364	65	61/94	36	38/107
• Then 6-12 months (if relevant)	46	137/301	27	59/215	6	2/33	13	9/69

**Denominators exclude those with data stated as being 'Not on alpha blockers''

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
4.2 Is there evidence of review for men on alpha blockers at: ** **%YES**								
• 4-6 weeks Not yet relevant	25	50/197	25	36/144	42	5/12	57	8/14
• 4-6 weeks (if relevant)	50	73/147	31	33/108	-	0/7	-	0/6
• 6-12 months Not yet relevant	46	98/214	40	66/165	50	6/12	53	8/15
• Then 6-12 months (if relevant)	54	63/116	31	31/99	-	0/6	14	1/7

**Denominators exclude those with data stated as being 'Not on alpha blockers

Table 53: Review on 5-AR (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
4.3 Is there evidence of a review for men on 5-AR therapy at: ** **%YES**								
• 3-6 months Not yet relevant	35	107/310	36	105/291	55	41/74	35	40/114
• 3-6 months (if relevant)	34	70/203	28	52/186	12	4/33	11	8/74
• 6-12 months Not yet relevant	46	165/356	47	152/322	67	61/91	38	44/117
• Then 6-12 months (if relevant)	29	56/191	18	31/170	-	0/30	11	8/73

**Denominators exclude those with data stated as being 'Not on 5-AR''

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
4.3 Is there evidence of a review for men on 5-AR therapy at: ** **%YES**								
• 3-6 months Not yet relevant	50	60/121	33	39/118	18	2/11	50	7/14
• 3-6 months (if relevant)	43	26/61	19	15/79	-	0/9	-	0/7
• 6-12 months Not yet relevant	63	88/139	44	60/135	45	5/11	53	8/15
• Then 6-12 months (if relevant)	31	16/51	8	6/75	-	0/6	-	0/7

**Denominators exclude those with data stated as being 'Not on 5-AR''

Table 54: Review on anti-cholinergics (MEN)

65+	Acute (Hospital) N=1271		Primary Care N=826		Mental Health N=244		Care Home N=328	
	%	N	%	N	%	N	%	N
4.4 Is there evidence of a review for men on anti-cholinergics at: ** **%YES**								
• 4-6 weeks Not yet relevant	27	91/341	30	94/317	53	41/78	39	41/106
• 4-6 weeks (if relevant)	38	95/250	37	83/223	22	8/37	5	3/65
• 6-12 months Not yet relevant	42	163/386	43	146/343	69	64/93	41	46/111
• Then 6-12 months (if relevant)	42	93/223	28	56/197	3	1/29	8	5/65

**Denominators exclude those with data stated as being 'Not on anti-cholinergics',

<65	Acute (Hospital) N=559		Primary Care N=445		Mental Health N=45		Care Home N=34	
	%	N	%	N	%	N	%	N
4.4 Is there evidence of a review for men on anti-cholinergics at: ** **%YES**								
• 4-6 weeks Not yet relevant	30	58/193	14	23/166	23	3/13	43	6/14
• 4-6 weeks (if relevant)	55	74/135	45	65/143	10	1/10	-	0/8
• 6-12 months Not yet relevant	44	92/211	30	53/174	31	4/13	47	7/15
• Then 6-12 months (if relevant)	62	74/119	35	42/121	11	1/9	13	1/8

**Denominators exclude those with data stated as being 'Not on anti-cholinergics',

Good Practice in Continence Services, DH 2000: *A copy of care plan should be given to the patient.*

Table 55: Care Plan Communication

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
4.5 Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient? **%YES**	15	396/2672	22	496/2265	26	62/235	34	201/596

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
4.5 Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient? **%YES**	22	595/2717	29	510/1765	35	24/69	27	9/33

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent'

Good Practice in Continence Services (DH 2000). *Where appropriate, a copy of care plan should be given to the carer.*

Table 56: Care Plan Communication

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
4.6 Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? **%YES**	8	225/2683	16	332/2071	29	117/403	49	442/900

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
4.6 Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? **%YES**	4	92/2105	10	136/1395	25	18/71	54	27/50

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

Good Practice in Continence Services (DH 2000).*There should be documented evidence of a full discussion of the cause and treatment of incontinence with the patient.*

Table 57: Care Plan Communication

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
4.7 Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence? **%YES**	51	1391/2728	59	1370/2310	37	89/240	59	346/589

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent to participate in such discussion'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
4.7 Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence? **%YES**	74	2030/2738	77	1382/1796	55	38/69	58	22/38

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent to participate in such discussion'

Documentation of discussion with patients occurs in the majority of cases in hospitals and in primary care. Older people are less likely to have a documented discussion.

Good Practice in Continence Services (DH 2000). *There should be documented evidence of a full discussion of the cause and treatment of incontinence when appropriate with the carer.*
NICE CG 97: 3.2.9: *Ensure that, if appropriate, men's carers are informed and involved in managing their LUTS and can give feedback on treatments.*

Table 58: Care Plan Communication

65+	Acute (Hospital) N=3282		Primary Care N=2612		Mental Health N=539		Care Home N=1139	
	%	N	%	N	%	N	%	N
4.8 Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? **%YES**	17	460/2680	32	673/2111	35	145/409	67	609/912

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

<65	Acute (Hospital) N=2813		Primary Care N=1880		Mental Health N=114		Care Home N=68	
	%	N	%	N	%	N	%	N
4.8 Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? **%YES**	11	227/1990	22	305/1374	40	25/62	58	32/55

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

The proportion of cases with a documented discussion with their carer is low in each healthcare setting but particularly so in hospitals and in primary care. Attention should be given to this, particularly as auditors have indicated that this would have been relevant in these cases.

BOWEL FULL NATIONAL RESULTS

Table 60: Documentation of Frequency of FI

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
1.1 How often is the patient incontinent of faeces?								
Not known	6	102	7	81	5	16	1	6
Not documented	29	535	25	278	9	30	0.1	1
If known and documented:								
• Every day/night	56	668/1187	56	422/757	44	132/303	57	389/686
• More than once weekly	31	367/1187	31	234/757	42	126/303	36	247/686
• Less than once weekly	13	152/1187	13	101/757	15	45/303	7	50/686

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
1.1 How often is the patient incontinent of faeces?								
Not known	5	58	10	60	1	1	4	2
Not documented	30	330	24	146	5	4	4	2
If known and documented:								
• Every day/night	45	326/718	51	207/407	36	27/76	50	25/50
• More than once weekly	25	178/718	22	92/407	11	8/76	6	3/50
• Less than once weekly	30	214/718	27	108/407	54	41/76	44	22/50

Frequency of FI was documented in 65% of younger and older acute hospital patients and two-thirds of patients in primary care. Documentation was higher in mental health hospitals and care homes.

Where frequency was documented, just over half of older patients in acute hospital, primary care and care home were incontinent every day/night; the rate was lower in mental health cases (44%). The rate of daily FI was generally slightly lower for younger patients. Patients with a frequency of less than once weekly were much more likely to be in the younger age group.

Frequency of FI is an essential measure of severity and should always be documented at baseline assessment and at every review. This was the primary outcome of interest in the recent NICE guidelines (NICE CG 49) and is very much linked to impact on quality of life.

Older patients in this audit were more likely than younger patients to have daily incontinence - whether this is due to age-associated severity or to less rigorous treatment needs to be explored.

NICE CG49

- *People with the comorbidities listed in Q1.2 are at risk of FI and should be asked proactively about symptoms [NICE CG49 - 'healthcare professionals should actively yet sensitively enquire about symptoms in high-risk groups']*
- *Many people with FI also suffer from UI - the two conditions must both be addressed for either to be effectively treated*
- *Assessment of patients with FI must include a relevant medical history and general examination to identify potentially modifiable comorbidities (e.g. diabetes, impaired mobility, Parkinson's disease)*
- *For patients with mobility impairment, every effort must be made to organise easy toilet access to promote continence – 'People with limited mobility who continue to have episodes of FI should be offered a regimen that will produce a planned, predicted bowel action when carers are present if needed' (NICE CG49)*
- *'People with neurological or spinal disease/injury who continue to have episodes of FI should be offered a neurological bowel management programme' (NICE CG49)*

'It is essential that people with learning difficulties follow the same initial care pathway as other people with FI. They may require addition support during assessment and management to achieve equal outcomes' (NICE CG49)

Table 61:

65+	**Acute (Hospital) N=1824**		**Primary Care N=1116**		**Mental Health N=349**		**Care Home N=693**	
	%	**N**	**%**	**N**	**%**	**N**	**%**	**N**
1.2 What other relevant conditions does the patient have either currently or in the past? **%YES**								
• Anorectal surgery	4	82	4	50	2	6	0.7	5
• Colorectal carcinoma	5	84	5	59	2	7	2	17
• Cervical myelopathy	0.7	13	0.1	1	-	0	0.1	1
• Dementia	33	611	28	308	82	286	71	492
• Diabetes	13	241	17	195	17	60	13	90
• Diverticular disease	9	161	10	110	2	6	4	27
• Faecal loading or chronic constipation	19	344	11	125	15	54	11	79
• Impaired mobility	44	795	36	400	39	137	64	443
• Inflammatory bowel disease	2	38	3	32	0.9	3	2	11
• Irritable bowel syndrome	2	34	3	39	1	4	2	12
• Neurological disease	11	208	12	136	9	30	11	73
• Pelvic radiotherapy	1	26	2	20	-	0	0.1	1
• Pelvic surgery	5	98	6	62	0.3	1	0.3	2
• Spinal cord disease/trauma	3	55	4	43	1	5	1	10
• Stroke	24	441	17	195	12	42	29	199
• Trauma at childbirth	4	68	1	11	-	0	0.3	2
• Urinary incontinence	40	735	33	372	62	218	68	470
• No documentation of these	6	102	8	94	3	10	0.6	4
• Other*	24	441	26	290	10	36	10	70

*Others (Acute Hospitals) -NON-MALIGNANT COLORECTAL DISEASE 46, RECENT SURGERY 47, LEARNING DISABILITY 9, CANCER PROSTATE OR BLADDER 33 ,DEPRESSION 22,ALCOHOL DEPENDENCY 5 , HYPOTHYROID 20, STOMA 1, OTHER 258

*Others (Primary Care) -NON-MALIGNANT COLORECTAL DISEASE 20, RECENT SURGERY 19, LEARNING DISABILITY 6, CANCER PROSTATE OR BLADDER 19 , DEPRESSION 27, ALCOHOL DEPENDENCY 3 , HYPOTHYROID 9, STOMA 2, OTHER 185

*Others (Mental Health) -NON-MALIGNANT COLORECTAL DISEASE 1, RECENT SURGERY 2, CANCER PROSTRATE OR BLADDER 3 , DEPRESSION 9, ALCOHOL DEPENDENCY 1 , STOMA 1, OTHER 19

*Others (Care Homes) -NON-MALIGNANT COLORECTAL DISEASE 4, RECENT SURGERY 8, LEARNING DISABILITY 2, CANCER PROSTATE OR BLADDER 3 , DEPRESSION 8, HYPOTHYROID 4, STOMA 1, OTHER 40

Table 61:

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
1.2 What other relevant conditions does the patient have either currently or in the past? **%YES**								
• Anorectal surgery	10	109	7	40	4	3	2	1
• Colorectal carcinoma	2	19	3	17	-	0	-	0
• Cervical myelopathy	0.3	3	-	0	-	0	-	0
• Dementia	4	39	3	16	21	17	33	18
• Diabetes	8	85	7	44	7	6	9	5
• Diverticular disease	5	50	4	26	1	1	-	0
• Faecal loading or chronic constipation	14	150	15	91	10	8	7	4
• Impaired mobility	15	163	23	139	40	32	50	27
• Inflammatory bowel disease	5	54	5	31	1	1	2	1
• Irritable bowel syndrome	7	75	9	58	-	0	-	0
• Neurological disease	17	184	35	217	19	15	46	25
• Pelvic radiotherapy	0.8	9	0.7	4	-	0	-	0
• Pelvic surgery	9	100	6	38	1	1	2	1
• Spinal cord disease/trauma	6	67	11	65	2	2	2	1
• Stroke	5	58	5	30	4	3	15	8
• Trauma at childbirth	17	186	4	26	-	0	-	0
• Urinary incontinence	21	233	26	157	60	49	50	27
• No documentation of these	13	142	6	38	4	3	-	0
• Other*	22	244	27	164	28	23	9	5

*Others (Acute Hospitals) -NON-MALIGNANT COLORECTAL DISEASE 27, RECENT SURGERY 6, LEARNING DISABILITY 37, CANCER PROSTATE OR BLADDER 2 , DEPRESSION 30, ALCOHOL DEPENDENCY 33 , HYPOTHYROID 4, OTHERS 105
*Others (Primary Care) -NON-MALIGNANT COLORECTAL DISEASE 8, RECENT SURGERY 7 , LEARNING DISABILITY 55 , DEPRESSION 17 ,ALCOHOL DEPENDENCY 10 , HYPOTHYROID 2, STOMA 3, Others 62
*Others (Mental Health) -LEARNING DISABILITY 13, DEPRESSION 7, OTHERS 3
*Others (Care Homes) -LEARNING DISABILITY 2 , DEPRESSION 1, ALCOHOL DEPENDENCY 2

Comorbidities

For older people the most common 'other relevant conditions (currently or in the past)' were dementia (acute 33%, primary 28%, mental health 82%, care home 71%), impaired mobility (44%, 36%, 39%, 64%), stroke (24%, 17%, 12%, 29%), diabetes (13%, 17%, 17%, 13%), and urinary incontinence (40%, 33%, 62%, 68%).

Younger people in acute hospital were more likely to have had anorectal (10%) or pelvic surgery (9%) or trauma at childbirth (17%). Neurological disease was prevalent (acute 17%, primary 35%, mental health 19%, care home 46%), with dementia (21%, 33%) and impaired mobility (40%, 50%) common in mental health and care homes respectively. Coexistent urinary incontinence was also common (21%, 26%, 60%, 50%).

People with the comorbidities are at risk of FI and should be asked proactively about symptoms.
Many people with FI also suffer from UI - the two conditions must both be addressed for either to be effectively treated.
Assessment of patients with FI must include a relevant medical history and general examination to identify potentially modifiable comorbidities (e.g. diabetes, impaired mobility, Parkinson's disease).

Table 62: Identification of causes

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
1.3 Is there documented evidence that the following factors have been identified in this case? **%YES**								
1.3i Faecal incontinence related to colorectal faecal loading	26	476	18	205	12	42	9	59
1.3ii Faecal incontinence related to functional disability	33	610	38	426	38	134	55	383
1.3iii Faecal incontinence due to loss of cognitive awareness	29	524	28	318	66	232	71	489
1.3iv Faecal incontinence related to co-morbidity	30	547	30	337	13	47	23	156
1.3v Anorectal incontinence (weak anal sphincters or anorectal condition)	15	280	11	126	1	5	2	16

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
1.3 Is there documented evidence that the following factors have been identified in this case? **%YES**								
1.3i Faecal incontinence related to colorectal faecal loading	18	194	26	161	9	7	7	4
1.3ii Faecal incontinence related to functional disability	17	192	38	234	54	44	54	29
1.3iii Faecal incontinence due to loss of cognitive awareness	10	112	20	125	53	43	63	34
1.3iv Faecal incontinence related to co-morbidity	23	255	34	206	10	8	24	13
1.3v Anorectal incontinence (weak anal sphincters or anorectal condition)	35	392	16	101	4	3	6	3

In mental health and care home settings, functional disability and cognitive impairment were predominant associated factors, regardless of age. In acute hospital patients; faecal loading, functional disability, low cognition and comorbidity were important factors in older people, while younger patients most commonly had anorectal conditions.

Within the acute sector, audit data on younger patients were more likely to be outpatient-based which may have influenced this aetiological case-mix. In primary care, by contrast, faecal loading, functional disability and comorbidity were prevalent causes in younger people.

Faecal loading is a reversible cause of FI that must be identified and treated - this audit shows it to be prevalent in patients of all ages and across all settings.

NICE CG49: 1.9.1: *When assessing faecal incontinence health professionals should:*

- *be aware that FI is a symptom, often with multiple contributory factors for an individual*
- *avoid making simplistic assumptions that causation is related to a single primary diagnosis.*

NICE CG49: 1.9.2.6: *People with limited mobility who continue to have episodes of FI after initial management should be offered a regimen that will produce a planned, predicted bowel action when carers are present if needed.*

NICE CG49: 1.9.2.6: *People with neurological or spinal disease/injury resulting in FI who continue to have episodes of FI after initial management should be offered a neurological bowel management programme.*

NICE CG49: 1.9.2.6: *people with learning difficulties may require addition support during assessment and management to achieve equal outcomes.*

NICE CG49**: **1.9.2.3: *Healthcare professionals should discuss with people with FI that a combination of initial management interventions is likely to be needed to address FI.*

Table 63: Assessment - Bowel History

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.1 Is there documented evidence of a bowel history? **%YES**	59	1084	73	817	46	161	57	392
2.1i does the history of faecal incontinence include**: **%YES**								
• Duration of symptoms	71	768	72	585	60	97	77	280/362
• Daytime symptoms	61	663	70	571	84	135	92	333/362
• Nocturnal symptoms	44	473	49	403	76	122	89	321/362

****** Denominators excludes 30 care homes with 'Records not available'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.1 Is there documented evidence of a bowel history? **%YES**	76	840	81	499	53	43	69	37
2.1i does the history of faecal incontinence include**: **%YES**								
• Duration of symptoms	81	683	79	392	67	29	81	30
• Daytime symptoms	67	561	72	358	79	34	92	34
• Nocturnal symptoms	40	339	51	256	72	31	92	34

****** Denominators excludes 30 care homes with 'Records not available'

41% of patients in acute care, 27% in primary care, 54% in mental health and 43% in care homes had no bowel history in the current audit. Documentation was comparatively better in younger patients (though still suboptimal).

Of those patients with a bowel history, duration was less well-documented than day/night symptoms in mental health and care home settings, while the reverse was true in acute hospitals and primary care. Nocturnal symptoms were generally the least well-recorded.

Adults with FI are likely to have comorbidities and functional impairments that may contribute to the symptoms, but that may also be modifiable through multidisciplinary assessment.
For patients with mobility impairment, every effort must be made to organise easy toilet access to promote continence.
It is essential that people with learning difficulties follow the same initial care pathway as other people with FI.

NICE CG 49: Chapter 3. 3.1: *For most patients with FI, a thorough basic assessment will provide enough information for the clinician to recommend an initial management strategy without recourse to more formal testing.*

This basic assessment MUST include bowel history documenting duration of symptoms and pattern of incontinence. A stool diary or bowel chart is a simple tool for documenting stool frequency, pattern and consistency and should be used in any patient being assessed for causes of FI.

Table 64: Assessment - History

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.2 Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence? **%YES**	45	820	43	482	34	117	58	402

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.2 Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence? **%YES**	28	305	41	250	47	38	63	34

Use of a stool diary or bowel chart was generally less than 50%, with greatest use in care homes. Lowest usage was in younger patients in the acute care sector.

NICE CG49: 1.9.1: *When assessing faecal incontinence health professionals should:*

- *be aware that FI is a symptom, often with multiple contributory factors for an individual*
- *avoid making simplistic assumptions that causation is related to a single primary diagnosis.*

Table 65: Assessment - Urinary incontinence

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.3 Is the patient incontinent of urine?* **%YES**	71	1199/1682	69	702/1020	88	303/346	94	649/690
2.3i If yes, is the patient catheterised because of incontinence?** **%YES**	32	368/1142	17	111/650	1	4/299	8	55/649

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.3 Is the patient incontinent of urine?* **%YES**	45	441/990	56	312/556	84	66/79	94	51/54
2.3i If yes, is the patient catheterised because of incontinence?** **%YES**	34	107/314	20	59/299	6	4/62	31	16/51

**Denominators exclude those with data stated as being 'Not documented'

The great majority of patients in mental health and care homes were also incontinent of urine – rates of catheterisation for incontinence within this group were low for older (1-8%) but higher (6-31%) for younger patients. Nearly half of younger patients in acute and primary health care were doubly incontinent, with similar catheterisation rates as for the older group. Urinary catheterisation rates were high in acute hospitals - patients with urinary incontinence should only be catheterised according to indications set out in NICE CG40.

- People with urinary incontinence are at risk of FI, and so the symptom should be actively enquired about.
- The two conditions often coexist, even in younger patients, and may share common causative factors.
- Both conditions should be actively managed to achieve quality of life gains.

NICE CG49:1.9.2.3/3.15.4: *When reviewing medication, healthcare professionals should consider alternatives to drugs which might be contributing to faecal incontinence.*

Table 66: Assessment – Medication Review

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.4 Is the patient on medication that exacerbates faecal incontinence?* **%YES** **2.4i** Has this medication been altered to minimise its impact	33	559/1711	30	297/974	31	101/323	28	192/674
• Yes	56	258/459	52	111/214	39	33/84	44	82/185
• No	22	103/459	20	43/214	12	10/84	11	21/185
• Not able to minimise further	21	98/59	28	60/214	49	41/84	44	82/185

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.4 Is the patient on medication that exacerbates faecal incontinence?* **%YES** **2.4i** Has this medication been altered to minimise its impact	18	180/1007	26	144/549	36	27/76	41	21/51
• Yes	44	67/154	49	54/110	50	11/22	50	10/20
• No	25	39/154	25	27/110	18	4/22	20	4/20
• Not able to minimise further	31	48/154	26	29/110	32	7/22	30	6/20

**Denominators exclude those with data stated as being 'Not documented'

Around one-third of older patients across settings were on medications that may exacerbate FI. The rate was notably lower (18%) for younger patients in acute hospitals. Most patients had the medication either altered or reviewed so that it could not be further minimised. Overall though, up to a quarter of patients had no action relating to medication.

Medication review is part of the initial management of FI to address reversible causes.

Medication side-effects commonly cause loose stool consistency leading to FI (e.g. laxatives, PPIs, SSRIs, iron supplements, diabetic oral therapies, NSAIDs).

Conversely, constipating medications (e.g. opiate-related analgesia, anticholinergic medications, calcium channel blockers) may lead to FI by causing faecal loading.

Treatment of FI should aim towards enabling a person to live with dignity, and to participate in whatever social, work, cultural activities they wish to.

Table 67: Assessment - Impact on Quality of Life

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.5 Is there evidence that the impact of symptoms on quality of life have been recorded?								
• Yes	21	375	34	377	17	58	34	237
• No	57	1034	48	541	31	108	29	199
• Mentally incompetent to undergo assessment	23	415	18	198	52	183	37	257
2.5i If YES, has a standardised assessment scale been used e.g. Faecal Incontinence Quality of Life Scale?** **%YES**	16	53/339	38	124/329	21	11/52	25	50/204

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.5 Is there evidence that the impact of symptoms on quality of life have been recorded?								
• Yes	41	448	53	323	31	25	31	17
• No	52	579	38	234	31	25	31	17
• Mentally incompetent to undergo assessment	7	79	9	56	38	31	37	20
2.5i If YES, has a standardised assessment scale been used e.g. Faecal Incontinence Quality of Life Scale?** **%YES**	21	87/405	40	117/292	11	2/18	21	3/14

**Denominators exclude those with data stated as being 'Not documented'

The impact of FI on quality of life (QOL) QOL was least likely to be documented in the acute setting for both age groups. Younger people were generally more likely than older people to have been assessed.

Use of standardised assessment tools for QOL was most frequent in primary care, and more often used with younger people. The nature of these standardised tools was not asked. This is an unexpected finding.

Regular FI is known to impact QOL and this impact should always be assessed.

Measuring impact on QOL is important for guiding specialist care – one indication for surgical repair in people with external anal sphincter defect is FI symptoms restricting QOL (NICE CG49).

NICE CG49: 1.9.2.6/2.6.3: *Health professionals should take a proactive approach to bowel management for specific groups of people:*

- *People with cognitive or behavioural issues*
- *People with limited mobility*

NICE CG49: 1.9.1: *As FI is socially stigmatising condition, healthcare professionals should actively yet sensitively enquire about symptoms in high risk groups:*

- *Frail older people*
- *People with learning difficulties*
- *People with severe cognitive impairment.*

Table 68: Assessment – Cognitive status in older people

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.6 Has the patient's cognition been assessed?** **%YES**	71	1068/1496	69	592/853	95	308/325	80	519/645
2.6i Is the patient's cognitive status:								
• Insufficient information to calculate	23	415	35	391	8	29	2	14
If calculable:								
• Unimpaired	36	510/1409	43	313/725	5	17/320	7	46/679
• Mild	15	206/1409	18	128/725	7	22/320	15	104/679
• Moderate	20	280/1409	21	150/725	26	83/320	36	242/679
• Severe	29	413/1409	18	134/725	62	198/320	42	287/679
2.6ii Is there documented use of a formal scoring system for assessment of cognition? **% YES**	58	620/1068	38	225/592	83	256/308	48	250/519

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.6 Has the patient's cognition been assessed?** **%YES**	49	372/765	65	288/444	85	58/68	78	38/49
2.6i Is the patient's cognitive status:								
• Insufficient information to calculate	25	279	35	214	21	17	2	1
If calculable:								
• Unimpaired	80	661/827	67	267/399	5	3/64	8	4/53
• Mild	5	38/827	10	40/399	20	13/64	32	17/53
• Moderate	6	53/827	8	31/399	19	12/64	23	12/53
• Severe	9	75/827	15	61/399	56	36/64	38	20/53
2.6ii Is there documented use of a formal scoring system for assessment of cognition? **% YES**	30	110/372	26	76/288	69	40/58	34	13/38

**Denominators exclude those with data stated as being 'Not documented'

Some type of cognitive assessment was documented for the majority of older patients across settings, but formal scoring systems (e.g. Abbreviated Mental Health Score) were used in only 38-58% of patients, outside of mental health sites. The majority of younger patients in mental health and care homes had moderate-severe cognitive impairment.

- When providing professional support, consideration should be given to an individual's cognition.
- Cognitive assessment must included in the focussed baseline examination (where relevant).
- Patients with severe cognitive impairment or learning difficulties may require neuropsychological and behavioural assessment leading to specific interventions founded on structured goal planning that might aim to resolve as well as manage FI.

Table 69: Assessment – Functional status

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.7 Has the patient's functional ability been assessed?** **%YES**	82	1282/1565	80	711/891	85	266/313	83	510/617
2.7i Is the patient's functional status:								
• Insufficient information to calculate	17	318	31	349	12	42	3	22
If calculable:								
• Unimpaired	21	320/1506	23	174/767	5	16/307	4	27/670
• Mild	14	204/1506	22	169/767	9	28/307	13	84/670
• Moderate	31	465/1506	29	220/767	34	104/307	40	266/670
• Severe	34	517/1506	27	204/767	52	159/307	44	293/670
2.7ii Is there documented use of a formal scoring system for assessment? **%YES**	36	466/1282	38	270/711	56	148/266	41	208/510

**Denominators exclude those with data stated as being 'Not documented'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.7 Has the patient's functional ability been assessed?** **%YES**	56	447/804	75	364/486	84	52/62	76	38/50
2.7i Is the patient's functional status:								
• Insufficient information to calculate	24	261	31	188	25	20	2	1
If calculable:								
• Unimpaired	66	558/845	41	174/425	11	7/61	8	4/53
• Mild	8	70/845	12	53/425	11	7/61	15	8/53
• Moderate	10	85/845	19	81/425	25	15/61	28	15/53
• Severe	16	132/845	28	117/425	52	32/61	49	26/53
2.7ii Is there documented use of a formal scoring system for assessment? **%YES**	26	116/447	24	87/364	69	36/52	32	12/38

**Denominators exclude those with data stated as being 'Not documented'

Over 80% of all older patients were functionally assessed, though formal scores (e.g. Barthel Index) were used in fewer than half. Nearly all patients in mental health and care homes, and most of those in acute and primary care had significant functional difficulties.

The pattern was similar in younger patients, though far fewer patients in acute and primary care were impaired.

NICE CG 49: 1.9.2.2: *The focused baseline assessment should comprise:*

- *relevant medical history*
- *a general examination*
- *an anorectal examination*
- *a cognitive assessment, if appropriate.*

Table 70: Examination – Basic Examination

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.8 Is there documented evidence of rectal examination to exclude faecal loading?								
• Yes	53	961	29	322	19	65	15	101
• No	46	847	69	775	79	274	81	559
• No, but patient has a colostomy or some other form of faecal diversion	1	16	2	19	3	10	5	33

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.8 Is there documented evidence of rectal examination to exclude faecal loading?								
• Yes	67	737	36	218	10	8	7	4
• No	32	358	63	387	84	68	87	47
• No, but patient has a colostomy or some other form of faecal diversion	1	11	1	8	6	5	6	3

While 70-80% of patients in acute care and 59-64% in primary care underwent digital rectal examination (DRE) as part of a focussed assessment, DRE to specifically exclude faecal loading, was documented in only 53-67% (acute) and 29-36% (primary). Rates for this basic assessment were even lower in mental health and care home sectors.

- Digital rectal examination to specifically exclude faecal loading was poorly documented, despite this being a basic requirement to guide treatment
- DRE to exclude faecal loading can be undertaken by qualified nurses without specialist continence training in any setting (www.**rcn**.org.uk/__data/assets/pdf_file/0009/78588/002062.pdf)

NICE CG 49: 1.9.2.3: *People with continuing FI after specialised conservative management should be considered for specialist assessment.*

Table 71: Examination – Focused Examination

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.9 Is there documented evidence that a focused examination has been performed? **%YES**	69	1257	49	548	44	152	25	176
2.9i If yes, who has performed the examination?								
• Geriatrician	19	244	8	42	0.7	1	2	4
• Gynaecologist	1	12	1	8	-	0	2	3
• GP	0.9	11	17	91	5	8	33	58
• Nurse	3	41	32	175	11	17	44	78
• Therapist	0.6	7	0.9	5	-	0	-	0
• Urologist	1	14	1	8	1	2	4	7
• Hospital ward based doctor	52	658	26	140	78	118	9	16
• Gastroenterologist	8	99	7	40	1	2	6	10
• Other (Colorectal surgeon)	12	147	6	34	-	0	-	0
• Other (Others)	2	24	1	5	3	4	-	0
Documented evidence** **(% YES)** of:								
2.9ii a Assessment of mobility	78	856/1097	75	366/487	91	123/135	97	157/162
2.9ii b Examination of abdomen for palpable mass or bladder retention	93	1153/1241	71	361/511	85	117/138	74	114/155
2.9ii c Examination of perineum and anus.	60	726/1206	61	321/526	34	38/112	62	96/155
2.9ii d Rectal examination	70	850/1222	59	304/513	41	46/112	63	100/156
2.9ii e Bowel imaging	47	487/1047	28	120/434	6	5/81	31	43/137
2.9ii f Neurological examination, if neurological symptoms suspected	53	458/861	28	111/395	33	29/87	27	33/123

**Denominators exclude those stated as being 'Not Required'

Table 71: Examination – Focused Examination

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.9 Is there documented evidence that a focused examination has been performed? **%YES**	83	923	64	392	28	23	30	16
2.9i If yes, who has performed the examination?								
• Geriatrician	4	37	1	4	-	0	-	0
• Gynaecologist	6	53	3	13	4	1	-	0
• GP	0.4	4	19	76	-	0	-	0
• Nurse	7	62	37	145	4	1	94	15
• Therapist	0.3	3	0.5	2	4	1	-	0
• Urologist	1	12	2	6	-	0	6	1
• Hospital ward based doctor	34	314	15	59	61	14	-	0
• Gastroenterologist	15	135	9	37	9	2	-	0
• Other (Colorectal surgeon)	29	271	7	29	-	0	-	0
• Other (Others)	3	32	5	21	17	4	-	0
Documented evidence** **(% YES**) of:								
2.9ii a Assessment of mobility	63	344/549	69	222/321	94	16/17	100	14/14
2.9ii b Examination of abdomen for palpable mass or bladder retention	92	798/863	70	250/356	100	21/21	79	11/14
2.9ii c Examination of perineum and anus.	77	680/884	67	241/361	33	5/15	25	2/8
2.9ii d Rectal examination	80	708/884	64	235/366	47	7/15	29	2/7
2.9ii e Bowel imaging	57	439/769	33	100/307	33	5/15	17	1/6
2.9ii f Neurological examination, if neurological symptoms suspected	42	204/482	35	91/263	14	2/14	50	4/8

**Denominators exclude those stated as being 'Not Required'

Focused examinations were performed in 69% of older people in acute hospitals, 49% in primary care, 44% in mental health and only 25% in care homes. Younger people in acute (83%) and primary care (64%) were more likely to have a focussed examination. Digital rectal examination in older people was performed too infrequently for optimal practice. Aside from the acute sector (80%), Bowel imaging was slightly more common in younger people. Only 53% of older and 42% of younger patients in acute hospitals had a neurological examination where neurological symptoms were suspected, with even lower rates in other sectors. Mobility was generally assessed in most patients.

Digital rectal examination should be attempted and documented in all patients with FI. In practice, pelvic floor exercises /anal sphincter strengthening exercises can be taught (and feedback given) during a DRE (NICE CG49).

Neurological examination where neurological symptoms are suspected is essential. FI is more prevalent in neurologically-impaired patients than in age and gender-matched controls. Such patients with persistent FI should be offered specific treatment (bowel management program) (NICE CG49).

Stool cultures and abdominal x-rays are useful tests in patients with loose stool (excluding infection and overflow from impaction respectively). Constipation, rectal evacuation difficulties or rectal prolapse may each contribute to FI in some patients. Imaging may help to define these problems (NICE CG49).

FI may be a presenting symptom of lower gastrointestinal cancer and appropriate tests (e.g. colonoscopy) should be done in those with a clinical index of suspicion. This includes older people in whom bowel cancer is more prevalent.

Table 72: Examination

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.10 For which tests is there documented evidence to aid diagnosis?								
2.10i Stool culture								
• Yes	24	440	14	155	13	47	11	75
• No	47	865	59	664	41	142	44	303
• No, but specialist records unavailable for audit	2	32	12	135	9	33	15	107
• Not required	27	487	15	162	36	127	30	208
2.10ii Abdominal x-ray								
• Yes	27	493	12	139	6	20	4	28
• No	50	918	62	687	45	156	48	331
• No, but specialist records unavailable for audit	2	29	13	142	11	37	17	118
• Not required	21	384	13	148	39	136	31	216
2.10iii Colonoscopy								
• Yes	21	380	10	111	1	4	1	10
• No	52	940	61	681	48	169	50	344
• No, but specialist records unavailable for audit	1	27	13	149	10	35	17	119
• Not required	26	477	16	175	40	141	32	220
2.10iv Other*								
• Yes	14	254	6	62	3	10	1	8

*Others (Acute Hospital) – Abdominal ultrasound or CT or MRI 103, Anorectal manometry and/or endoanal ultrasound 73, Barium enema 22, Biopsy 7, Others 49
*Others (Primary care) – Abdominal ultrasound or CT or MRI 14, Anorectal manometry and/or endoanal ultrasound 11, Barium enema 11, Biopsy 1, Others 25
*Others (Mental Health) – Others 10 *Others (Care Homes) – Others 8

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.10i Stool culture								
• Yes	13	143	10	59	11	9	2	1
• No	50	548	56	346	51	41	44	24
• No, but specialist records unavailable for audit	2	19	15	90	12	10	9	5
• Not required	36	396	19	118	26	21	44	24
2.10ii Abdominal x-ray								
• Yes	23	257	18	108	6	5	-	0
• No	47	525	50	307	56	45	44	24
• No, but specialist records unavailable for audit	1	13	16	96	12	10	11	6
• Not required	28	311	17	102	26	21	44	24
2.10iii Colonoscopy								
• Yes	41	448	14	87	1	1	-	0
• No	36	403	53	323	59	48	44	24
• No, but specialist records unavailable for audit	1	16	15	95	11	9	11	6
• Not required	22	239	18	108	28	23	44	24
2.10iv Other* *								
• Yes	26	293	9	57	1	1	-	0

**Others (Acute Hospital) – Abdominal ultrasound or CT or MRI 46, Anorectal manometry and/or endoanal ultrasound 184 Barium enema 15, Biopsy 12, Others 36
**Others (Primary care) – Abdominal ultrasound or CT or MRI 14, Anorectal manometry and/or endoanal ultrasound 9, Barium enema 10, Biopsy 5, Others 19
**Others (Mental Health) – Others 1

Tests to aid diagnosis were most likely to be documented in the acute setting. Overall, the rates of using stool culture and abdominal x-ray in those considered to require them was no greater than a third of cases. Younger (v older) patients were much more likely to undergo colonoscopy (41% v 21% in the acute setting). Colonoscopy rates outside the acute sector were far lower**.**

Table 73: Diagnosis – Identifying clear causes(s) of FI

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
2.11 Is there documented evidence of a clear identification of the types or causes of bowel problem?								
• Yes	51	933	49	543	32	111	37	257
• No	48	872	46	514	62	217	44	305
• No, but specialist records unavailable for audit	1	19	5	59	6	21	19	131

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
2.11 Is there documented evidence of a clear identification of the types or causes of bowel problem?								
• Yes	68	747	65	401	30	24	24	13
• No	32	354	29	179	64	52	44	24
• No, but specialist records unavailable for audit	0.5	5	5	33	6	5	31	17

Records were frequently unavailable in care homes. Only half of older people in acute and primary care sectors had a documented diagnosis – the rate was higher for younger people at 68% and 65% respectively. Less than a third of patients in mental health care had a clear diagnosis.

Documentation of clearly identified cause(s) of FI was poor, particularly in residential care where it may reflect a lack of focussed assessment.
Lack of documentation of cause(s) of FI will evidently inhibit effective treatment, care planning, and communications with patients and carers/family.

Table 74: Management – Condition-specific treatment

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.1 Is there documented evidence that **condition-specific intervention** has been given or planned for the following:** **%YES**								
3.1i Faecal loading?	47	589/1251	34	277/811	37	73/197	32	145/447
3.1ii Potentially treatable causes of diarrhoea?	40	423/1052	33	248/758	21	33/156	23	93/407
3.1iii Rectal prolapse or third-degree haemorrhoids?	12	90/767	8	45/600	3	3/117	6	21/333
3.1iv Acute anal sphincter injury?	8	56/723	5	26/574	0.9	1/109	0.6	2/312
3.1v Acute disc prolapse/cauda equina syndrome?	3	20/683	2	11/558	-	0/109	0.6	2/309

**Denominators exclude those stated as being 'Not appropriate'

Table 74: Management – Condition-specific treatment

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
3.1 Is there documented evidence that **condition-specific intervention** has been given or planned for the following:** **%YES**								
3.1i Faecal loading?	49	276/566	51	218/427	23	9/40	42	11/26
3.1ii Potentially treatable causes of diarrhoea?	47	243/518	37	136/371	14	7/48	29	7/24
3.1iii Rectal prolapse or third-degree haemorrhoids?	23	89/387	7	19/289	5	2/40	6	1/18
3.1iv Acute anal sphincter injury?	28	122/431	8	24/291	3	1/40	6	1/17
3.1v Acute disc prolapse/cauda equina syndrome?	9	29/333	5	14/284	5	2/40	6	1/18

**Denominators exclude those stated as being 'Not appropriate'

Treatment for faecal loading was the commonest condition-specific intervention in both age groups and across the 4 settings. In primary care, more younger (51%), than older (34%) patients were treated for faecal loading, whilst rates in acute hospitals were similar (47-49%). Anorectal conditions were much more commonly treated in younger (51%) than older (20%) acute hospital patients, as were cauda equina syndromes (9% versus 3%).

People with the following causes should have condition-specific interventions with aim of resolving FI: faecal loading, potentially treatable causes of diarrhoea, warning signs for lower GI cancer, rectal prolapse, third-degree haemorrhoids, acute anal sphincter injury, acute disc prolapse/cauda equine syndrome (NICE CG49).
Chronic diarrhoea is a common cause of FI in older people Markland AD, Goode PS, Burgio KL, Redden DT, Richter HE, Sawyer P, Allman RM.. J Am Geriatr Soc. 2010 and should be properly assessed.
Full treatment options for anorectal conditions causing FI should be discussed with patients, regardless of age.

Table 75: Management – Treatment goals

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.2 Are the patient's goals for treatment recorded?** **%YES**	31	411/1332	41	366/903	39	57/145	55	210/382

**Denominators exclude those stated as being 'No, but the patient is incompetent to partake in decision making''

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
3.2 Are the patient's goals for treatment recorded?** **%YES**	42	401/954	53	289/549	50	30/60	62	21/34

**Denominators exclude those stated as being 'No, but the patient is incompetent to partake in decision making''

Recording of patient goals for treatment was done most consistently in care homes (55-62%) and least in the acute hospital sector (31-42%). This patient-centred indicator was more likely to be documented in younger than older patients.

Table 76: Treatment

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.3 Did the patient require treatment? **%YES**	73	1327	76	852	50	173	40	275

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
3.3 Did the patient require treatment? **%YES**	82	906	87	532	46	37	26	14

Table 77: Management – Treatment plan for those requiring treatment

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.4 Did the patient have a treatment plan?* **%YES**	55	1004	63	707	55	192	44	306

Table 190: Management – Treatment plan for those requiring treatment

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
3.4 Did the patient have a treatment plan?* **%YES**	69	764	75	461	53	43	59	32

Older people were generally less likely to have documented treatment plans than younger people. Rates in both age groups were highest in primary care. Further analysis showed that >10% of patients reported as not requiring treatment were also reported as having documented treatment plans. When this group was removed from the analysis, the rate of documented treatment plans in those reported as requiring treatment was significantly greater.

Table 78: Management – Treatment methods

The denominators below are those who either required treatment and/or had a treatment plan.

65+	Acute (Hospital) N=1381		Primary Care N=903		Mental Health N=216		Care Home N=326	
	%	N	%	N	%	N	%	N
3.5 Which of the following methods of treatment have been used or planned? **%USED OR PLANNED**								
3.5i Advice on general health	23	315	49	444	29	63	57	186
3.5ii Advice on lifestyle	24	325	48	433	24	52	55	180
3.5iii Antidiarrhoeal drugs	20	280	17	156	6	14	23	74
3.5iv Biofeedback	8	114	4	34	0.5	1	8	25
3.5v Bowel clearance programme	21	284	18	164	15	32	22	73
3.5vi Bowel retraining	10	139	20	185	6	14	17	57
3.5vii Dietician	27	377	15	134	28	61	47	154
3.5viii Faecal incontinence chart	38	525	39	356	38	83	70	227
3.5ix Implementation of bowel training regimes / techniques	12	170	25	224	13	29	28	90
3.5x Improved mobility	36	499	23	207	31	67	31	101
3.5xi Improved quality of, and access to, toilet facilities	17	235	20	181	31	68	45	147
3.5xii Pelvic floor training	12	160	14	123	3	6	6	21
3.5xiii Laxatives / enemas/ suppositories	49	682	37	336	52	113	64	209
3.5xiv Management of behavioural problems in severe dementia	9	118	10	87	50	109	53	174
3.5xv Review of medication	45	621	37	333	58	125	74	242
3.5xvi Rectal irrigation	2	34	4	34	1	2	4	14
3.5xvii Specific pharmacological interventions, e.g: metronidazole for *C. difficile*	8	107	5	47	2	5	10	32
3.5xviii Colostomy or ileostomy	3	45	1	13	1	2	5	16
3.5xix Surgery	9	128	6	56	2	5	5	16
3.5xx Toileting advice	17	229	34	310	36	77	48	157
3.5xxi Toileting schedules	15	207	30	269	57	123	78	254
3.5xxii Treatment of co-morbidities	39	533	24	219	19	42	25	82
3.5xxiii Other*	6	80	8	69	1	3	2	7

*Others (Acute Hospitals) – Pads 6, Sacral nerve stimulation 14, Other containment eg plugs, bowel management 18, Other 42

*Others (Primary Care) – Pads 29, Sacral nerve stimulation 4, Other containment eg plugs, bowel management 13, Other 23

*Others (Mental Health) – Pads 1, Other containment eg plugs, bowel management 2

*Others (care Homes) – Pads 2, Other containment eg plugs, bowel management 4, Other 1

<65	Acute (Hospital) N=930		Primary Care N=553		Mental Health N=44		Care Home N=32	
	%	N	%	N	%	N	%	N
3.5i Advice on general health	39	365	61	337	70	31	72	23
3.5ii Advice on lifestyle	43	404	63	350	66	29	72	23
3.5iii Antidiarrhoeal drugs	29	273	20	112	11	5	9	3
3.5iv Biofeedback	23	212	8	47	2	1	-	0
3.5v Bowel clearance programme	19	174	28	157	5	2	25	8
3.5vi Bowel retraining	21	191	28	156	18	8	13	4
3.5vii Dietician	18	164	18	100	50	22	50	16
3.5viii Faecal incontinence chart	21	199	33	184	55	24	63	20
3.5ix Implementation of bowel training regimes / techniques	22	200	33	181	20	9	16	5
3.5x Improved mobility	13	123	11	63	27	12	25	8
3.5xi Improved quality of, and access to, toilet facilities	6	56	18	100	30	13	16	5
3.5xii Pelvic floor training	30	282	25	136	2	1	-	0
3.5xiii Laxatives / enemas/ suppositories	38	349	49	269	50	22	47	15
3.5xiv Management of behavioural problems in severe dementia	2	22	2	13	9	4	13	4
3.5xv Review of medication	30	275	40	223	43	19	38	12
3.5xvi Rectal irrigation	7	61	13	72	2	1	-	0
3.5xvii Specific pharmacological interventions, e.g: metronidazole for *C. difficile*	7	62	4	21	7	3	6	2
3.5xviii Colostomy or ileostomy	5	51	3	19	-	0	3	1
3.5xix Surgery	17	159	9	51	9	4	3	1
3.5xx Toileting advice	20	186	40	219	43	19	56	18
3.5xxi Toileting schedules	12	112	29	163	41	18	66	21
3.5xxii Treatment of co-morbidities	23	210	18	101	16	7	28	9
3.5xxiii Other**	12	108	7	40	7	3	-	0

**Others (Acute Hospitals) – Pads 5, Sacral nerve stimulation 52, Other containment eg plugs,bowel management 10, Other 41
**Others (Primary Care) – Pads 8, Sacral nerve stimulation 3, Other containment eg plugs, bowel management 10, Other 19
**Others (Mental Health) – Other 3

Overall, younger patients were much more likely to receive lifestyle and health advice than older patients.

Active treatment of FI should involve a combination of methods to achieve results
Lifestyle and health advice should be included in all treatment plans.
Healthcare professionals should recommend a diet (food and fluid intake) that promotes an ideal stool consistency and predictable bowel emptying (NICE CG49).
Toileting advice should include encouraging people to (a) empty their bowel after a meal to utilise the gastrocolic reflex, (b) adopt a sitting or squatting position, (c) use techniques to facilitate bowel emptying and avoid straining.
Healthcare professionals should verify that toilet facilities are private, comfortable and accessible.
Where problems with access are identified, appropriate assistive equipment and help (e.g. mobility assessment, occupational therapy, personal home care) should be provided.
'All people with FI considering or being considered for surgery should be referred to a specialist surgeon to discuss (a) surgical and non-surgical options appropriate for their individual circumstances, (b) potential benefits and limitations of each option with particular attention to long-term results, and (c) realistic expectations of the effectiveness of any surgical procedures under consideration' (NICE CG 49).
'A trial of temporary sacral nerve stimulation should be considered for people with FI in whom sphincter surgery is deemed inappropriate' (NICE CG 49).

Table 79: Management – Other providers of Treatment

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.6 Is there documented history of referral to other providers of treatment? **%YES**								
• Colorectal surgeon	17	318	13	143	3	10	1	10
• Bowel dysfunction practitioner	5	90	3	33	0.9	3	1	6
• Continence practitioner	9	159	17	186	14	49	18	124
• Dietitian	16	290	9	101	20	70	23	162
• Gastroenterologist	10	174	5	59	1	4	2	16
• General practitioner (GP)	9	158	20	221	8	27	47	326
• Geriatrician	19	343	7	81	1	4	6	40
• Neurologist	4	69	4	48	2	7	3	18
• Practice nurse	3	62	3	31	4	13	7	47
• Unable to retrieve data, records not available on site	-	0	-	0	-	0	4	26
• Not documented	12	224	18	197	16	56	9	59
• Other*	9	169	7	77	3	9	3	9
• None of the above	27	498	28	308	52	180	26	178

*Others (Acute Hospitals) – Psychiatry 26, Urologist/Gynaecologist 40, Therapist 40, Other 63
*Others (Primary Care) – Psychiatry 13, Urologist/Gynaecologist 11, Therapist 27, Other 26
*Others (Mental Health) – Psychiatry 2, Urologist/Gynaecologist 1, Therapist 3, Other 3
*Others (Care Homes) – Psychiatry 5, Urologist/Gynaecologist 2, Other 2

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
• Colorectal surgeon	36	394	19	117	5	4	-	0
• Bowel dysfunction practitioner	18	203	7	44	1	1	-	0
• Continence practitioner	14	152	24	149	16	13	31	17
• Dietitian	10	113	9	53	25	20	17	9
• Gastroenterologist	15	166	8	48	9	7	2	1
• General practitioner (GP)	12	128	27	164	19	15	30	16
• Geriatrician	3	33	0.7	4	1	1	-	0
• Neurologist	8	86	15	90	4	3	17	9
• Practice nurse	3	35	1	9	2	2	6	3
• Unable to retrieve data, records not available on site	-	0	-	0	-	0	9	5
• Not documented	8	83	11	69	15	12	7	4
• Other**	10	114	9	57	5	4	-	0
• None of the above	18	198	24	148	38	31	17	9

**Others (Acute Hospitals) – Psychiatry 12, Urologist/Gynaecologist 35, Therapist 25, Other 42
**Others (Primary Care) – Psychiatry 11, Urologist/Gynaecologist 15, Therapist 15, Other 16
**Others (Mental Health) – Psychiatry 1, Other 3

With regards to referral to other providers of treatment, referrals to specialists were highest in acute setting. For older people, the commonest referral was to geriatricians (19%). Younger people were more likely to be referred to colorectal surgeons (36% v 17% acute, 19% v 13% primary care), gastroenterologists (15% v 10% acute) and bowel dysfunction practitioners (18% v 5% acute). GPs were most commonly referred to in the community. 47% of older people living in care homes had been referred to their GP.

NICE CG49: Chapter 2. 2.3.2: *People perceive FI as 'part of getting old' and therefore something to be just dealt with – this stoicism may be linked to a lack of information about causes, treatment options and support structures.*
NICE CG49: 1.9.3: *During assessment, initial and long-term management, healthcare professionals should offer people with FI advice on coping strategies.*
NICE CG49. 1.9.2.5: Long term management. *Healthcare professionals should offer the following to symptomatic people who do not wish to continue with active treatment or who have intractable faecal incontinence:*

- *advice relating to the preservation of dignity and, where possible, independence*
- *psychological and emotional support, possibly including referral to counsellors or therapists if it seems likely that a person's attitude towards their condition and ability to manage and cope with faecal incontinence could improve with professional assistance*
- *at least 6 monthly review of symptoms*
- *discussion of any other management options*
- *contact details for relevant support groups*
- *advice on continence products and information about product choice, availability and use*
- *advice on skin care*
- *advice on how to talk to friends and family*
- *strategies such as planning routes for travel to ensure access to public conveniences, carrying toilet access card or RADAR key to allow access to disabled toilets in the National Key Scheme.*

Table 80: Management – Longer-Term

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.7 Is there documented evidence that long-term management of Faecal Incontinence has been given or planned?** **%YES**								
3.7i Advice and information on continence products	24	328/1349	64	646/1004	54	132/246	90	562/626
3.7ii Advice on skin care	28	382/1375	43	429/991	53	139/263	89	551/620
3.7iii Advice relating to preservation of dignity	23	324/1390	37	374/999	60	170/285	89	551/616
3.7iv Advice relating to preservation of independence	19	255/1312	31	294/941	44	115/261	79	413/521
3.7v Contact details for relevant support groups	8	101/1246	11	97/853	9	17/187	36	133/366
3.7vi Periodic review of symptoms	36	525/1455	53	538/1022	56	154/273	85	516/609
3.7vii Psychological and emotional support	22	299/1385	34	335/977	56	150/269	83	492/594

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
3.7 Is there documented evidence that long-term management of Faecal Incontinence has been given or planned?** **%YES**								
3.7i Advice and information on continence products	30	207/689	69	351/510	68	45/66	98	43/44
3.7ii Advice on skin care	29	199/697	52	268/511	54	38/70	98	45/46
3.7iii Advice relating to preservation of dignity	22	153/693	43	228/527	70	48/69	98	43/44
3.7iv Advice relating to preservation of independence	22	138/637	40	197/498	62	40/65	86	31/36
3.7v Contact details for relevant support groups	15	100/688	20	91/459	10	5/50	57	13/23
3.7vi Periodic review of symptoms	60	509/850	68	370/544	52	33/64	89	41/46
3.7vii Psychological and emotional support	33	260/779	46	241/526	52	33/63	91	42/46

**Denominators exclude those stated as 'Not required'

All measures of coping strategies in the context of long-term management were lowest in the acute care setting, and highest in care homes where over 80% of patients received psychological and emotional support and advice on important issues such as preserving dignity and independence. Outside the care home setting less than 20% received contact details for relevant support groups.

A care plan for long-term management should be considered for people who prefer symptomatic management to more invasive measures, or who have intractable FI.
Support through relevant groups plus appropriate counselling is very important in fostering acceptance and positivity (currently at low levels in community-living patients).
Treatment and care should take account of patients' needs and preferences. Information given to patients leading to shared treatment goals should be appropriate to each individuals' culture, cognition, and life situation (NICE CG49).
People with FI should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.
Self-treatment coping mechanisms should also be taken into account when making joint treatment goals (NICE CG49).

NICE CG49: *People with FI should be offered (a) disposable body worn pads in a choice of styles and disposable bed pads, (b) pads in sufficient quantity for the individual's continence needs, (c) anal plugs (if tolerated), (d) skincare advice covering cleansing and barrier products, (e) advice on odour control and laundry, (f) disposable gloves.*

Table 81: Management - Containment

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
3.8 Which of the following methods of management have been used or are planned for treatment?								
• Adapted clothing	3	61	6	67	6	21	13	89
• Advice on skin care and odour control	8	148	14	161	14	49	40	277
• Anal plugs	2	29	4	45	0.3	1	0.1	1
• Bags	1	19	0.6	7	0.9	3	4	27
• Devices to aid toileting	4	66	8	85	8	27	18	125
• Pads	59	1081	75	838	87	305	96	668
• Not documented	17	317	10	112	2	7	0.1	1
• Other*	3	60	3	33	1	3	0.3	2
• None of the above	18	335	11	121	9	31	2	13

*Others (Acute Hospitals) – Air mattress 2, Devices to aid toileting 3, Bags / rectal irrigation 10, Other 45
*Others (Primary Care) – Devices to aid toileting 7, Bags / rectal irrigation 2, Other 24
*Others (Mental Health) – Other 3
*Others (Care Homes) – Bags / rectal irrigation 1, Other 1

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
• Adapted clothing	1	13	6	36	12	10	15	8
• Advice on skin care and odour control	8	89	19	118	20	16	31	17
• Anal plugs	5	55	8	51	2	2	-	0
• Bags	1	13	1	8	2	2	6	3
• Devices to aid toileting	4	39	9	54	9	7	6	3
• Pads	30	335	53	331	80	65	93	50
• Not documented	24	263	14	88	2	2	-	0
• Other**	6	61	7	40	2	2	-	0
• None of the above	35	392	19	115	7	6	4	2

**Others (Acute Hospitals) – Devices to aid toileting 1, Bags / rectal irrigation 10, Other 50
**Others (Primary Care) – Devices to aid toileting 3, Bags / rectal irrigation 17, Other 20
*Others (Mental Health) – Other 2

The principle containment method used was pads, with only a small minority of patients receiving alternative devices, or even advice on skin care and odour control. The overall use of pads in older people in acute hospitals was lower in this audit (59%) than in 2005 (75%) and 2006 (80%), which may indicate a slight shift from passive containment to active assessment and management although these data should be treated with caution.

Good practice in continence services (DH, 2000) Targets for in-patient care: *Discharge plans should include a continence management plan, which should be shared with the patient and carer (once patients have consented to this).*

NICE CG49: 1.9.2.1: *Healthcare professionals should ensure that people with FI and their carers:*

- *are kept fully informed about their condition and have access to appropriate sources of information in formats and languages suited to their individual requirements;*
- *are offered access or made aware of appropriate support groups;*
- *have the opportunity to discuss assessment, management options and relevant physical, emotional and social issues.*

NICE CG49: 3.15.6: *After each intervention, healthcare professionals should ask the person if their FI has improved People continuing to experience symptoms should be:*

- *involved in discussions about further treatment options;*
- *asked if they wish to try further treatments.*

Table 82: Care Plan / Communication

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
4.1 Does the patient have a documented continence care plan? **%YES**	30	556	64	712	66	230	99.6	690
4.1i If yes, when was the patient's care plan last reassessed?								
No documentation of reassessment	18	98	9	63	3	8	0.3	2
If documented:								
• Less than 6 months	85	390/458	72	470/649	94	209/222	94	645/688
• 6-8 months	9	42/458	13	82/649	3	6/222	4	25/688
• 9-11 months	4	17/458	6	39/649	2	5/222	0.4	3/688
• 12 months or more	2	9/458	9	58/649	0.9	2/222	2	15/688

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
4.1 Does the patient have a documented continence care plan? **%YES**	33	369	66	405	75	61	100	54
4.1i If yes, when was the patient's care plan last reassessed?								
No documentation of reassessment	11	39	3	11	3	2	-	0
If documented:								
• Less than 6 months	84	278/330	70	276/394	68	40/59	98	53/54
• 6-8 months	11	36/330	15	61/394	14	8/59	2	1/54
• 9-11 months	3	11/330	7	26/394	7	4/59	-	0
• 12 months or more	2	5/330	8	31/394	12	7/59	-	0

A documented care plan was evident in almost all care home residents, in two-thirds of primary care and mental health cases but only one third of acute sector cases. The rate for older acute sector patients fell from 45% in 2006 to 30%. Most cases had been reassessed within 6 months.

Sharing care plans provides the opportunity to discuss assessment, management options, physical, emotional, psychological and social issues, and individuals' views, experiences, attitudes and opinions.
Well-documented care plans facilitate review of treatment (NICE CG49).

Table 83: Care Plan / Communication

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
4.2 Is there documented evidence that a copy of the care plan has been given to the patient?** **%YES**	7	89/1266	20	176/889	32	33/103	30	75/248

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
4.2 Is there documented evidence that a copy of the care plan has been given to the patient?** **%YES**	13	131/1002	24	130/547	36	12/33	26	7/27

**Denominators exclude those stated as 'No, but the patient is mentally incompetent'

Few people in the acute setting were given copies of the care plan, with rates rising only to 20-24% in primary care and up to 36% in mental health and care homes. This practice in acute hospitals has remained poor, 3% in 2005, 6% in 2006 and 7% in 2009.

Table 84: Care Plan / Communication

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
4.3 Is there documented evidence that a copy of the care plan has been given to the carer/relative?** **%YES**	7	108/1449	17	160/951	38	89/235	64	365/574

**Denominators exclude those stated as 'No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
4.3 Is there documented evidence that a copy of the care plan has been given to the carer/relative?** **%YES**	4	35/871	16	87/541	31	15/48	58	22/38

**Denominators exclude those stated as 'No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion'

Sharing care plans with carers/relatives (where relevant) was very infrequent in acute and primary care settings, though somewhat better in mental health and care homes.

***Good Practice in Continence Services (DH 2000)**. There should be documented evidence of a full discussion of the cause and treatment of the problem with the patient.*

Table 85: Care Plan / Communication

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
4.4 Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem?** **%YES**	40	497/1243	50	431/868	35	34/97	53	140/265

**Denominators exclude those stated as 'No, but the patient is mentally incompetent to participate in such discussion'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
4.4 Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem?** **%YES**	63	638/1008	67	362/537	50	15/30	59	17/29

**Denominators exclude those stated as 'No, but the patient is mentally incompetent to participate in such discussion'

Documented evidence of a full discussion of causes and treatments with patients was more frequent overall than providing patients with copies of care plans. Younger patients were more likely to receive such a discussion than older people. Discussion rates with older patients in the acute hospital sector have improved from 16% (2005) and 22% (2006) to 40% (2009).

Table 86: Care Plan / Communication

65+	Acute (Hospital) N=1824		Primary Care N=1116		Mental Health N=349		Care Home N=693	
	%	N	%	N	%	N	%	N
4.5 Is there documented evidence of a full discussion of the causes and treatments of the bowel problem with the carer/relative?** **%YES**	22	326/1451	32	305/957	48	109/226	74	440/591

**Denominators exclude those stated as 'No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion'

<65	Acute (Hospital) N=1106		Primary Care N=613		Mental Health N=81		Care Home N=54	
	%	N	%	N	%	N	%	N
4.5 Is there documented evidence of a full discussion of the causes and treatments of the bowel problem with the carer/relative?** **%YES**	17	144/834	34	181/535	36	15/42	68	27/40

**Denominators exclude those stated as 'No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion'

Discussion with carers or relatives of people in whom such a discussion may be relevant was best documented in care home residents (68-74%) as may be expected, but was strikingly low in acute hospitals (17-22%) and primary care (32-34%). Discussion rates in the acute hospital sector have improved from 13% (2005) and 18% (2006) to 22% (2009).

BLADDER AUDIT SCORE for patients/residents aged 65 years and over.

The audit questions used for the overall scoring are given in scoring system (see appendices). The plot below displays patient/resident variation in bladder audit scores for each sector. Higher scores constitute better scores.

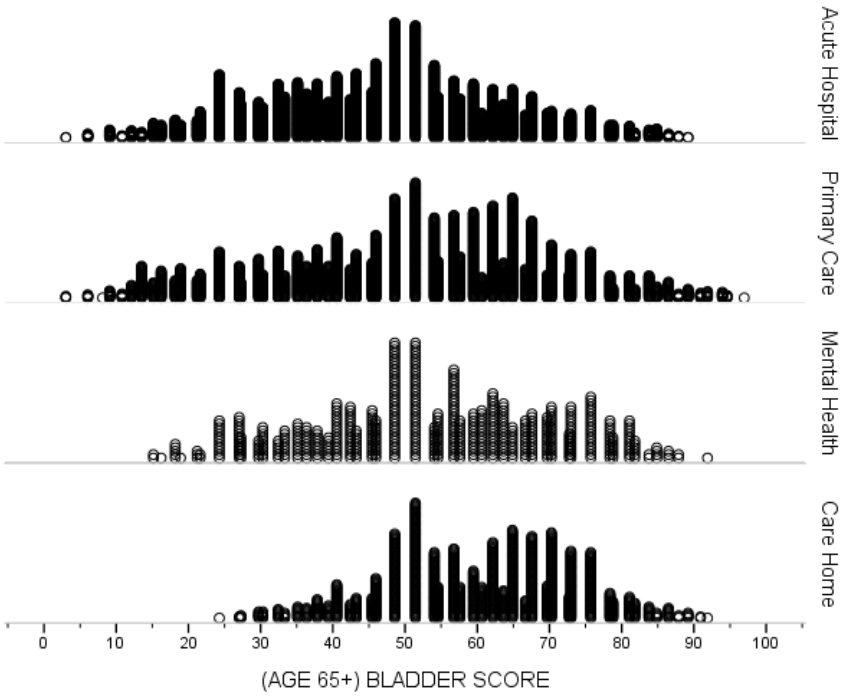


Figure 3

Table 95: Patient/Resident variation in bladder audit scores

65+	Acute (Hospital) N=3282	Primary Care N=2612	Mental Health N=539	Care Home N=1139
MEDIAN (IQR) score	46 (35-59)	52 (38-65)	55 (42-68)	61 (51-70)

BLADDER AUDIT SCORE for patients/residents aged < 65 years

The audit questions used for the overall scoring are given in scoring system (see appendices). The plot below displays patient/resident variation in bladder audit scores for each sector. Higher scores constitute better scores.

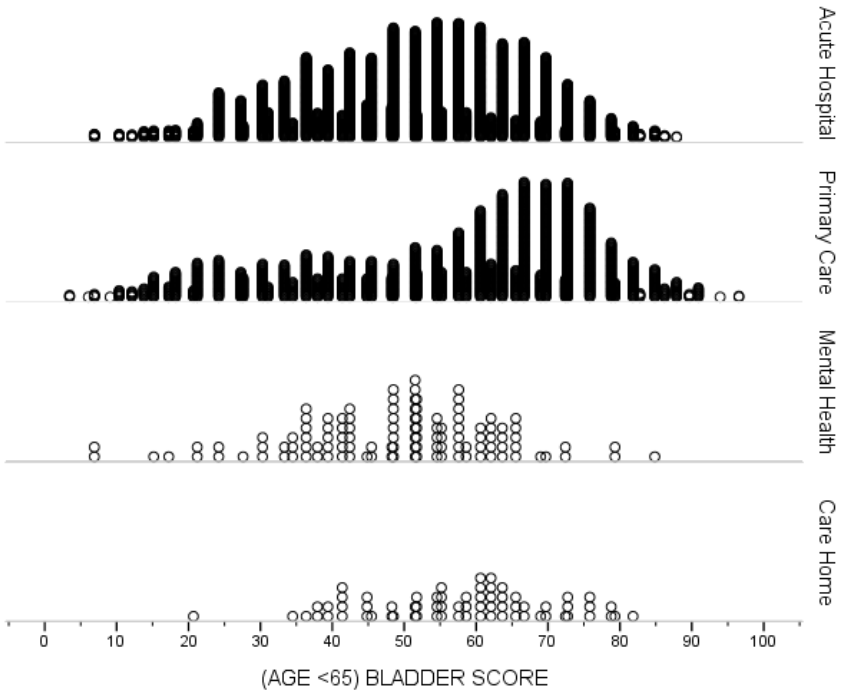


Figure 4

Table 97: Patient/Resident variation in bladder audit scores

<65	Acute (Hospital) N=2813	Primary Care N=1880	Mental Health N=114	Care Home N=68
MEDIAN (IQR) score	52 (39-62)	61 (42-70)	52 (39-58)	59 (48-66)

BOWEL AUDIT SCORE for patients/residents aged 65 years and over.

The audit questions used for the overall scoring are given in scoring system (see appendices).
The plot below displays patient/resident variation in bowel audit scores for each sector.
Higher scores constitute better scores.

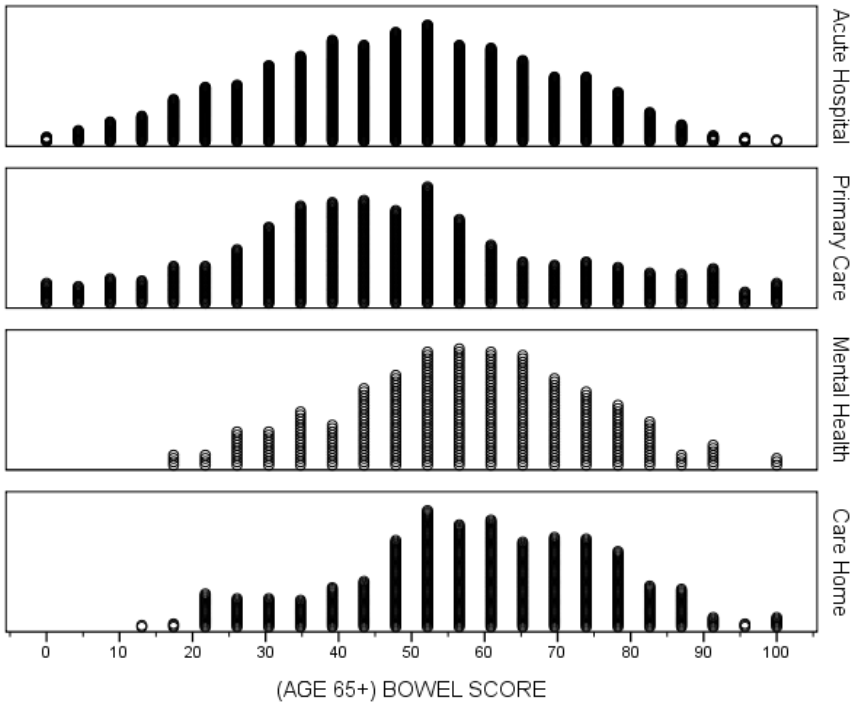


Figure 5

Table 110: Patient/Resident variation in bowel audit scores

65+	Acute (Hospital) N=1824	Primary Care N=1116	Mental Health N=349	Care Home N=693
MEDIAN (IQR) score	48 (32-62)	48 (32-62)	57 (45-67)	61 (45-71)

BOWEL AUDIT SCORE for patients/residents aged < 65 years

The audit questions used for the overall scoring are given in scoring system (see appendices).
The plot below displays patient/resident variation in bowel audit scores for each sector.
Higher scores constitute better scores.

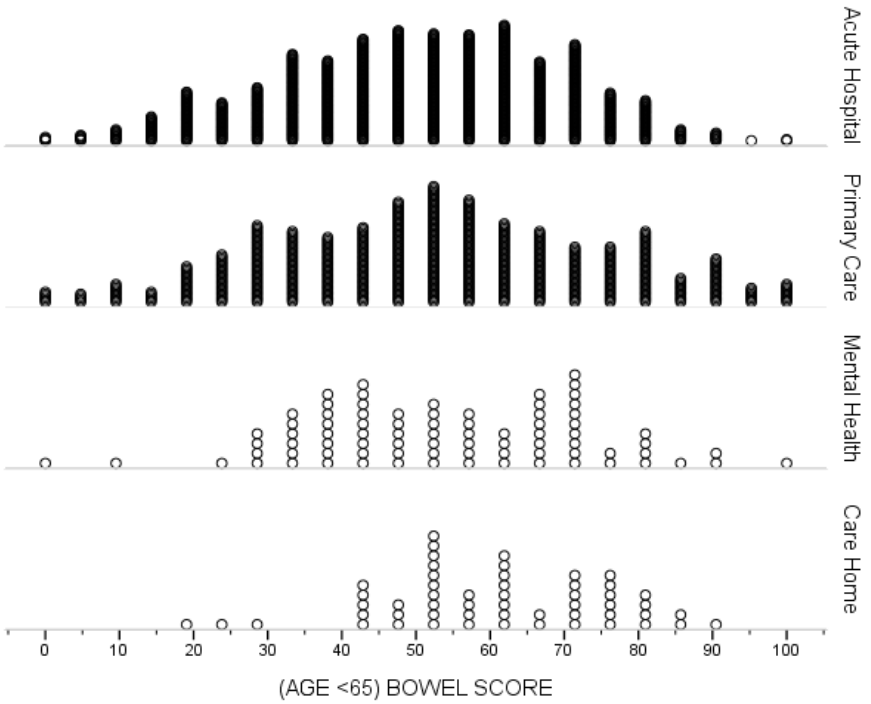


Figure 6

Table 112: Patient/Resident variation in bowel audit scores

<65	Acute (Hospital) N=1106	Primary Care N=613	Mental Health N=81	Care Home N=54
MEDIAN (IQR) score	52 (38-62)	52 (38-67)	52 (38-69)	62 (52-73)

TEMPORAL COMPARISONS: Over the three rounds of audit: 2005, 2006 and 2009 for the acute hospital sector in England, for patients aged 65 years and older

Questions that were the same, or very nearly the same, and with the same or very nearly the same answer options from the National Audits of Continence Care for 2005, 2006 and 2009 were compared across time. The 2005, 2006 or 2009 data were revisited and re-analysed as appropriate to gain as much comparability as possible with regard to denominators. Nevertheless there was a differing mix of hospitals making up each cross-sectional set of results and so strictly speaking the comparisons are not entirely like for like.

2009: 3282 cases, 139 sites
2006: 3801 cases, 167 sites
2005: 3257 cases, 169 sites

Table 99:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
1.1 Does the patient have: **%YES**						
• Nocturnal frequency (>2 voids /night)	21	690	24	910	34	1119
• Urinary frequency (>8 voids/24h)***	21	678	24	929	35	1154
• Nocturnal enuresis	21	688	25	938	21	699
• Urinary urgency	15	481	18	697	37	1215
• Urgency (urge) incontinence	11	369	17	638	35	1148
• Stress urinary incontinence (urine loss with coughing, straining, exertion)	7	231	11	407	24	778
• Post micturition dribble (MEN)	not	asked	not	asked	18	228/1271
• Clinically significant post void residual volume	7	229	8	309	16	533
• Voiding difficulty	10	335	13	476	24	774
• Intermittent catheter	not	asked	not	asked	8	248
• Permanent catheter	17	558	15	569	16	524
• Constipation	not	asked	23	882	20	641
• Bladder pain	not	asked	not	asked	8	264

*** was >7 voids/24h in 2005 & 2006 audits

Response options for this question 1.1 were PRESENT, ABSENT and NOT DOCUMENTED

Table 100:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
1.1 Does the patient have: **%with details 'NOT DOCUMENTED'**						
• Nocturnal frequency (>2 voids /night)	69	2252	62	2349	45	1477
• Urinary frequency (>8 voids/24h)***	67	2187	59	2231	44	1443
• Nocturnal enuresis	69	2246	62	2339	49	1622
• Urinary urgency	77	2500	70	2676	46	1524
• Urgency (urge) incontinence	80	2591	72	2726	46	1526
• Stress urinary incontinence (urine loss with coughing, straining, exertion)	82	2659	74	2831	50	1651
• Post micturition dribble (MEN)	not	asked	not	asked	60	767/1271
• Clinically significant post void residual volume	81	2634	76	2906	53	1724
• Voiding difficulty	76	2479	67	2554	44	1453
• Intermittent catheter	not	asked	not	asked	35	1153
• Permanent catheter	38	1232	37	1408	28	930
• Constipation	not	asked	45	1698	37	1224
• Bladder pain	not	asked	not	asked	49	1602

*** was >7 voids/24h in 2005 & 2006 audits

Table 101:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
1.2 What other documented conditions does the patient have either currently or in the past? **%YES**						
• Bladder cancer/stones	2	55	2	77	4	118
• Chronic cough	4	131	4	149	4	143
• Dementia	32	1036	27	1027	21	705
• Depression	11	358	10	363	9	294
• Diabetes	16	509	17	655	16	530
• Faecal loading or chronic constipation	9	282	8	304	8	251
• Heart failure	16	528	15	559	12	401
• Hypertension	29	956	28	1057	33	1074
• Impaired mobility	50	1617	45	1720	33	1076
• Neurological disease	14	449	12	466	12	397
• Obesity	4	115	4	153	4	148
• Urogenital atrophy (WOMEN)	not	asked	not	asked	4	88/2011
• Pelvic radiotherapy	0.3	11	0.4	14	1	39
• Pelvic surgery e.g. hysterectomy (WOMEN)	5	110/2005	8	184/2355	19	386/2011
• Prolapse (WOMEN)	4	85/2005	4	94/2355	12	238/2011
• Prostate disease or surgery (MEN)	21	257/1252	21	305/1446	35	445/1271
• Recurrent falls	23	733	23	865	15	505
• Spinal cord disease/trauma	2	66	2	84	2	83
• Smoking	6	182	5	202	5	173
• Stroke	31	996	29	1111	16	509
• Trauma at childbirth (WOMEN)	0.5	11/2005	0.8	19/2355	2	34/2011
• Acute urinary tract infection**	27	887	26	1006	20	648
• Other	28	904	28	1071	28	908

*"Urinary tract infection" for 2005 & 2006

Table 102:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence? **% YES**						
• Stress urinary incontinence	5	152	5	204	14	451
• Mixed urinary incontinence	3	98	8	288	13	413
• Passive leakage	6	194	8	292	6	208
• Urgency urinary Incontinence*	8	250	9	341	18	596
• Detrusor overactivity / overactive bladder)*					10	321
• Functional	9	282	12	473	10	323
• Urinary tract infection	18	575	21	812	15	494
• Voiding difficulty	9	281	10	396	18	594
• Urogenital atrophy	not	asked	not	asked	2	54
• Other	8	272	5	209	2	68
• No diagnosis documented	54	1761	46	1748	29	961

*Asked in 2005 & 2006 as Urge Urinary Incontinence (Detrusor overactivity/overactive bladder)

There has been a gradual upward trend in the documentation of the likely cause or type of UI. However, a third of people still have no diagnosis written down

Table 103:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.1 Is there documented evidence of a continence history? **%YES**	44	1421	51	1950	62	2019
2.1i Does the history of urinary continence include:** **%YES**						
Daytime symptoms	52	737	60	1176	80	1615
Nocturnal symptoms	52	738	59	1147	72	1445

****** Denominators excludes care home residents with 'Records not available'

Table 104:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.2 Is the patient is incontinent of faeces? **%YES**	27	865	22	837	17	569

Minor question differences: 2005 & 2006 "Is it documented that the patient is incontinent of faeces?"

Table 105:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.3 Is the patient's bowel habit documented? **%YES**	61	2001	65	2469	60	1981

Table 106:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.5 Is there documented evidence of the use of any bladder diary**? ** %YES**	15	354/2394	18	523/2883	30	840/2836

Denominators exclude those with data stated as being 'NO, but** patient is incompetent to use a chart/diary'

Table 107:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.18 Is there documented evidence of measurement of post-void residual volume (PVR) using ultrasound or catheterisation? (WOMEN) ** **%YES**	19	351/1849	23	509/2193	40	773/1954

**Denominators exclude those with data stated as being 'No, but consent could not be gained'

Table 108:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
2.28 Is there documented evidence of a clear identification of the type/cause of urinary incontinence? **%YES**	23	760	34	1282	58	1916

Table 109:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
3.15 Which of the following methods of containment have been used or are planned for treatment? **%YES**						
• Body worn pads (disposable)	56	1821	57	2161	48	1570
• Body worn pads (re-usable)					1	34
• All-in-one disposable	not	asked	not	asked	2	76
• All-in-one (re-usable)	not	asked	not	asked	0.2	5
• Reusable products (pants)	not	asked	not	asked	3	110
• Bed protection	12	390	14	515	7	226
• Indwelling catheter	33	1064	31	1184	26	844
• Intermittent catheterisation	4	115	4	169	6	213
• Devices	5	158	5	172	3	90
• Penile Clamps	not	asked	not	asked	<0.1	1/1271
• Containment not part of care plan	3	86	4	145	11	346
• Not documented	12	388	10	382	18	577
• Other	6	192	5	172	1	43

Table 110:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
4.1 Does the patient have a documented continence care plan? **%YES**	41	1327	44	1656	42	1379
4.1i when was the patient's care plan last reviewed?						
• Less than 6 months	96	1268	83	1376	76	1043
• 6-8 months	1	16	2	33	9	123
• 9-11 months	0.5	7	2	28	2	28
• 12 months or more	2	23	2	33	3	43
• No documentation of reassessment	1	13	11	186	10	142

Table 111:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
4.7 Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence? **%YES**	19	419/2202	29	783/2727	51	1391/2728

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent to participate in such discussion'

Table 112:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
4.8 Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? **%YES**	11	311/2763	14	477/3310	17	460/2680

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

Table 113:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
4.5 Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient? **%YES**	4	95/2306	6	180/2846	15	396/2672

**Denominators exclude those with data stated as being 'No, but the patient is mentally incompetent'

Table 114:

Question	2005 N=3257		2006 N=3801		2009 N=3282	
	%	N	%	N	%	N
4.6 Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? **%YES**	4	114/2783	5	152/3362	8	225/2683

**Denominators exclude those with data stated as being 'No, but the patient has no relevant carer/relative, doesn't wish carer/relative to be informed or is mentally incompetent'

There has been a small improvement in the proportion of people who receive care according to recognised national guidelines over the period of the audits. There is still, however, considerable room for improvement.

TEMPORAL COMPARISONS: Over the three rounds of audit: 2005, 2006 and 2009 for the acute hospital sector in England, for patients aged 65 years and older

Questions that were the same, or very nearly the same, and with the same or very nearly the same answer options from the National Audits of Continence Care for 2005, 2006 and 2009 were compared across time. The 2005, 2006 or 2009 data were revisited and re-analysed as appropriate to gain as much comparability as possible with regard to denominators. Nevertheless there was a differing mix of hospitals making up each cross-sectional set of results and so strictly speaking the comparisons are not entirely like for like

Table 115:

Question	2005 N=1565		2006 N=2249		2009 N=1824	
	%	N	%	N	%	N
How often is the patient incontinent of faeces?						
Not known	6	101	5	107	6	102
Not documented	25	398	25	571	29	535
If known and documented:						
• Every day/night	47	501	44	698	56	668/1187
• More than once weekly	42	451	43	674	31	367/1187
• Less than once weekly	11	114	13	199	13	152/1187
Is there documented evidence that the following factors have been identified in this case?						
• Faecal incontinence related to colorectal faecal loading	15	227	16	370	26	476
• Faecal incontinence related to functional disability	30	477	38	848	33	610
• Faecal incontinence due to loss of cognitive awareness	29	459	33	734	29	524
• Faecal incontinence related to co-morbidity	22	339	33	734	30	547
• Anorectal incontinence	6	91	11	257	15	280
Is there documented evidence of a bowel history?	45	702	49	1107	59	1084
If yes, does the history of faecal incontinence include:						
• Duration of symptoms	46	325	58	646	71	768
• Daytime symptoms	43	300	59	651	61	663
• Nocturnal symptoms	37	262	52	571	44	473
Is the patient incontinent of urine?	85	1335	86	1925	66	1199
Is there evidence that the impact of symptoms on quality of life have been recorded?						
• Yes	11	168	11	258	21	375
• No	58	914	57	1271	57	1034
• Mentally incompetent to undergo assessment	31	483	32	720	23	415
If yes, has a standardised assessment scale been used e.g. Faecal Incontinence Quality of Life Scale?	13	16/128	17	38/218	16	53/339
Is there documented evidence of rectal examination to exclude faecal loading?						
• Yes	34	537	37	832	53	961
• No	64	1005	62	1386	46	847
• No, but documented evidence of rectal examination to exclude faecal loading	1	23	1	31	1	16
Is there documented evidence of a clear identification of the types or causes of bowel problem?						
• Yes	26	407	33	745	51	933
• No	72	1125	66	1485	48	872
• No, but specialist records unavailable for audit	2	3	1	19	1	19
Is there documented history of referral to other providers of treatment?						
• Colorectal surgeon	7	113	5	112	17	318
• Bowel dysfunction practitioner	not	asked	not	asked	5	90
• Continence practitioner	not	asked	not	asked	9	159
• Dietitian	21	329	19	435	16	290
• Gastroenterologist	7	111	7	160	10	174
• General practitioner (GP)	4	58	3	68	9	158
• Geriatrician	33	510	24	548	19	343
• Neurologist	3	51	4	81	4	69
• Practice nurse	1	22	1	22	3	62
• Not documented	42	652	48	1078	12	224
• None of the above					27	498

Table 115: (continued)

Which of the following methods of management have been used or are planned for treatment?						
• Adapted clothing	4	55	4	80	3	61
• Advice on skin care and odour control	12	189	11	239	8	148
• Anal plugs	0.3	4	0.5	11	2	29
• Bags	0.8	13	2	37	1	19
• Devices to aid toileting	not	asked	not	asked	4	66
• Pads	75	1171	80	1794	59	1081
• Not documented	23	359	17	378	17	317
Does the patient have a documented continence care plan?	37	577	45	1002	30	556
If yes, when was the patient's care plan last reassessed?						
No documentation of reassessment	not	asked	12	123/1002	18	98/556
If documented:						
• Less than 6 months	96	552	97	849/879	85	390/458
• 6-8 months	0.7	4	2	17/879	9	42/458
• 9-11 months	2	10	1	9/879	4	17/458
• 12 months or more	2	9	0.5	4/879	2	9/458
Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem?**	16	138/841	22	272/1247	40	497/1243
Is there documented evidence of a full discussion of the causes and treatments of the bowel problem with the carer/relative?**	13	168/1258	18	336/1845	22	326/1451

**Denominators exclude those stated as 'No, but ....."'

Questions with minor differences:

Question	2005	
	%	N
2005 – Is there documented evidence that a stool diary has been used to record frequency of incontinence?	34	532/1565
2006 – Is there documented evidence that a stool diary has been used to record frequency of incontinence?	43	970/2249
2009 – Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence?	45	820/1824

Question	2005	
	%	N
2005 – Has a copy of the care plan been given to the patient?	3	24/913
2006 – Is there documented evidence that a copy of the care plan has been given to the patient?	6	78/1331
2009 – Is there documented evidence that a copy of the care plan has been given to the patient?**	7	89/1266

**Denominators exclude those stated as 'No, but ..."'

Question	2005	
	%	N
2005 – Has a copy of the care plan been given to the carer/relative?	4	52/1255
2006 – Is there documented evidence that a copy of the care plan has been given to the carer/relative?	6	113/1860
2009 – Is there documented evidence that a copy of the care plan has been given to the carer/relative?**	7	108/1449

**Denominators exclude those stated as 'No, but ..."'

In a similar fashion to that seen with the clinical bladder questions, for the majority of indicators, there has been a small improvement in the proportion of sites reporting compliance as time has progressed. There is still, though, much to achieve to ensure a high quality service.

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Appendices

APPENDIX 1: Members of National Audit of Continence Care Steering Group

Members of National Audit of Continence Care Steering Group	Representing
Dr Adrian Wagg, Associate Director Professor of Health Ageing	CEEU, RCP / University of Alberta, Canada
Dr Danielle Harari, Deputy Associate Director	CEEU, RCP / British Geriatric Society
Dr Jonathan Potter, Clinical Director	CEEU, RCP
Ms Rhona Buckingham CEEU Manager	CEEU, RCP
Mrs Jan Husk, Project Manager	CEEU, RCP
Mr Jose Lourtie, Project Coordinator	CEEU, RCP
Ms Brenda Welbeck, Project Administrator	CEEU, RCP
Mrs Angela Billington	Director of Continence services, Bournemouth & Poole Community Health Services
Mr Jonathan Duckett	British Society of Urogynaecology
Ms Pamela Holmes	Age Concern & Help the Aged
Mr Ian Ireland	Director, IAI Consultancy
Ms Vian Jiawook	Lay member of the Steering Group
Prof Mike Kirby	Primary Care
Mrs Gaye Kyle	Association for Continence Advice / Bowel care expertise
Ms Joanne Mangnall	Royal College of Nursing
Dr Doreen McClurg	Association for Continence Advice - Executive Committee
Professor Christine Norton	Burdett Institute of Gastrointestinal Nursing
Ms Margit Physant	Age Concern & Help the Aged
Ms Ginny Storey	Head of Care Governance & Regulation, Anchor Care Homes
Dr Winn Tadd	Academic Department of Geriatric Medicine Cardiff University Academic Centre
Ms Julie Vickerman	PromoCon & Disabled Living Manchester
Dr Jonathan Webster	Fellow, Gerontological Nursing
Ms Mandy Wells	Integrated Bladder and Bowel Care
Ms Lesley Woolnough	Bladder & Bowel Foundation

APPENDIX 2: THE ORGANISATIONAL SCORING SYSTEM

The Organisational score can range from 0 to 33 for Acute Hospital and Primary Care sectors and from 0 to 30 for Mental Health and Care Home sectors. Raw sites scores have been scaled from 0 to 100. This appendix indicates which questions have been included in the scoring system and explains the scoring or weighting given to each item. These scores were developed using the nominal group method, following two rounds of scoring, by members of the continence working party. The mechanics of the scoring system following identification of the standards to be included was developed by the lead for the project and the project statistician in consultation with the working party.

	Question	Score
1.	**Policies and Procedures**	
1.1 1.1i 1.1ii 1.1iii	Does the facility (GP practice/ hospital /care home), or the service covering the facility, have a **written policy** for the management of continence? • Training for staff in continence care • Assessment and treatment of incontinence • A means for regular audit of continence services	1.1NO=0 1.1Yes and, 3 elements present, score 2 2 elements present score 1 0 OR 1 element present, score 0
1.5	Does the facility utilise an Integrated Care Pathway or an evidence based treatment algorithm for patients with incontinence? • Integrated care pathway • Algorithm • Care plan None of these	3 elements present, score 2 2 elements present, score 1 1 element present, score 0 NONE OF THESE = 0
1.6	Does the facility submit surgical audit data to the relevant specialist society database?	Yes 1 No/NA=0 This only scores for acute hospitals and primary care
2	**Screening**	
2.1	Is it the facility's practice to ask a screening question relating to bladder and bowel problems as part of the initial assessment?	YES=1 NO=0
2.2	Is there a written protocol for providing a basic assessment for all people who indicate that they have problems with urinary and/or faecal continence?	YES=1 NO=0
2.3 2.4	Does the facility routinely use a standardised measure to record functional ability for older patients (e.g. Barthel/MDS-RAI)? // Does the facility routinely use a standardised measure to record mental state (e.g. Abbreviated Mental Test Score, Mini-Mental State Examination)?	BOTH YES=1 EITHER OR BOTH NO = 0
2.6 2.6i 2.6ii 2.6iii 2.6iv	Does the clinical team include a practitioner who has had training to: • Take a continence history • Initiate a frequency-volume chart? • Perform a rectal examination? • Perform a urinalysis?	4 elements present, score 2 3 elements present, score 1 2 elements or less present, score 0
3.1	Does the facility have access to an integrated continence service (as defined by “Good Practice in continence services” (DoH 2000)	YES=1 NO=0
3.1i	If yes, does the service have: • Director of integrated services • Lead of integrated services • Continence nurse specialists • Specialist continence physiotherapists • Specialist continence occupational therapists • Unable to find the information from my local service	5 elements present, score 2 4 elements present, score 1 3 elements or less present, score 0 UNABLE TO FIND INFORMATION=0
3.1ii	~~If yes, does this service have designated referral pathways~~	8 elements present, score 2

	with:	
	• Gynaecology (including Urogynaecology) • Colorectal surgery • Urology • Gastroenterology • Geriatric Medicine • Neurology • Community continence service • Via GP specialist consultant None of the above Unable to find the information from my local service	6-7 element present, score 1 5 elements or less present, score 0 UNABLE TO FIND INFORMATION=0
3.2	Do the surgeons operating on people with urinary incontinence work as part of the multidisciplinary team?	Yes 1 No=0 This only scores for acute hospitals and primary care sectors
3.3	Is there a designated clinical surgical lead for continence and prolapse surgery within the unit?	Yes 1 No=0 This only scores for acute hospitals and primary care sectors
3.4	Does your local service have investigation and treatment facilities, which include access to: • Urodynamics • Urinary or gastrointestinal tract imaging • Anorectal physiology Unable to find the information from my local service None of the above	ALL 3 elements present, score 2 1-2 elements, score 1 NONE OF THE ABOVE = 0 UNABLE TO FIND INFORMATION=0
4	**Training**	
4.1	Is there a structured **programme of staff training** on promoting continence for the facility?	NO=0 YES=1
4.1i	If yes, does the **programme** include basic assessment (i.e. all of these: history taking, urinalysis, rectal examination and frequency/volume charting)	NO=0 YES=1
4.1ii 4.1iii	Does the service use any of the National Occupational Standards (Continence Care) to guide the content of its training? Does the service use any of the National Occupational Standards (Continence Care) to develop work based competency packages?	BOTH YES = 1 EITHER OR BOTH NO = 0 'NOT AWARE OF THESE' COUNTS AS NO
4.2	Do patients have access to a local continence practitioner, who is able to give advice on continence, and bladder and bowel care?	NO=0 YES=1
4.3	Is a specialist continence assessment always carried out by a practitioner with training in? • Knowledge of the aetiology of urinary and faecal incontinence • Experience in taking a history • Ability to carry out an abdominal examination • Ability to carry out a rectal examination • Ability to carry out a vaginal examination • Ability to perform urinalysis • Ability to carry out residual volume measurement None of the above Don't know	7 elements present, score 2 4-6 elements present, score 1 <4 elements, score 0 NONE OF THE ABOVE = 0 NOT KNOWN = 0
5	**Environment**	
5.1	Do the areas for both assessment AND treatment of patients with bladder and bowel problems preserve the patient's privacy and dignity according to current standards?	7-8 elements present – score 2 6-3 elements present – score 1 3 or fewer – score 0
5.1ii	If you have ticked Yes, which of the following does this include:	
	• Privacy around the bed area	
	• Privacy around the toilet area	
	• Easily accessible toilet facilities	
	• Appropriate aids to toileting (frames/rails etc)	
	• Privacy when staff speak to in-patients in confidence	

	• Privacy when staff speak to the out-patients in confidence	
	• Steps taken to reduce odour	
	• Hand washing after toileting	
6	**User Evaluation of the Service**	
6.1	Are there means in the care setting by which service users/patients can make • Suggestions • Complaints	BOTH YES = 1 EITHER NO OR BOTH NO = 0
6.2 **6.2i**	Is the bladder or bowel care delivered by the service subject to regular audit? If yes, does the audit assess the patient's concern regarding privacy and dignity?	BOTH YES = 1 EITHER NO OR BOTH NO = 0 'NOT KNOWN' COUNTS AS 'NO'
6.3	Does the continence service have a user group?	NO=0 YES=1 NOT KNOWN=0
7	**Continence Products**	
7.2	Does your **written policy** indicate that products are supplied on the basis of clinical and patient need rather than cost?	NO=0 YES=1 NOT KNOWN= 0
7.4	Is there a written policy for eliciting patient/carer views?	NO=0 YES=1 NOT KNOWN= 0
8	**Patient Carer Information and Support**	
8.1	Is evidence-based information about bladder and bowel care freely available to patients and carers?	YES ALL AREAS=1 YES SOME AREAS = 1 NO=0 NOT KNOWN=0

APPENDIX 3: THE SCORING SYSTEM FOR BLADDER AUDIT CASES

The score can range from -2 to 31 for males aged 65 years or over, from -2 to 27 for males younger than 65 years, -4 to 33 for females aged 65 years or over, -4 to 29 for females younger than 65 years. This appendix indicates which questions have been included in the scoring system and explains the scoring or weighting given to each item. These scores were developed using the nominal group method, following two rounds of scoring, by members of the continence working party. The mechanics of the scoring system following identification of the standards to be included was developed by the lead for the project and the project statistician in consultation with the working party. The raw scores as defined above were scaled from 0 to 100 for analysis and it is the scaled scores 0-100 that are summarised in the report, with 0 being the lowest (worst) score and 100 the highest (best) score.

QUESTION		Score
1.1	**A history of urinary symptoms** x. Intermittent catheter • Present • Absent • Not documented xi. Permanent catheter • Present • Absent • Not documented xii. Constipation • Present • Absent • Not documented xiii. Bladder pain • Present • Absent • Not documented	Present or absent scores 1, Not documented scores 0 RECORDS NOT AVAILABLE ON SITE scores 1 Present or absent scores 1, Not documented scores 0 RECORDS NOT AVAILABLE ON SITE scores 1 Present or absent scores 1, Not documented scores 0 RECORDS NOT AVAILABLE ON SITE scores 1 Present or absent scores 1, Not documented scores 0 RECORDS NOT AVAILABLE ON SITE scores 1
1.3	Is there documented evidence of a clear indication of the type/cause of urinary incontinence?	NO DIAGNOSIS DOCUMENTED scores 0 ANY OF THE LISTED OPTIONS(INCLUDING OTHER) scores 1
	Cognitive status	
1.4	Has the patient's cognition been assessed? **Over 65**	YES scores 1, NO scores 0 NOT DOCUMENTED scores 0
1.4ii	Is there documented use of a formal scoring system for assessment of cognition? **Over 65**	YES scores 1, N0 scores 0
	Functional status	
1.5	Has the patient's functional ability been assessed?	YES scores 1, NO scores 0 NOT DOCUMENTED scores 0
1.5ii	Is there documented use of a formal scoring system for assessment of functional ability?	YES scores 1, N0 scores 0
2	**Assessment**	
	History	
2.1	Is there documented evidence of a continence history?	YES scores 1 NO scores 0
2.3	Is the patient's bowel habit documented?	YES scores 1 NO scores 0
2.5	Is there documented evidence of the use of any bladder diary? (Men and women)	Q2.5YES scores 1 (male or female) Q2.5NoBut scores 1 (male or female) Q2.5No scores 0 (male or female)
2.4	Is there evidence of the use of a three day bladder diary? WOMEN	Q2.4YES scores +1 (female only) Q2.4NoBut scores +1 (female only) Q2.4No scores +0 (female only)
2.6	Is the patient on medication that may exacerbate urinary incontinence?	Q2.6YES scores 1 , Q2.6No scores 0
2.6i	Has this medication been altered to minimise its impact?	Q2.6YES & Q2.6iYES scores +1 Q2.6YES & Q2.6i(not able to minimise further) scores +1

		Q2.6YES & Q2.6iNO scores +0
2.7	Is there documented evidence that the impact of symptoms on quality of life has been assessed?	YES scores 1 NO scores 0 , NO BUT scores 1
2.8	Is there documented evidence that the impact of symptoms on quality of life has been recorded using a standard assessment scale? WOMEN	YES scores 1 NO scores 0 , NO BUT scores 1
2.9	Is there evidence of the use of a validated symptom score at initial assessment? MEN	YES scores 1 NO scores 0 , NO BUT scores 1
	Examination	
	Basic Examination	
2.10	Is there a documented indication for rectal examination? • Assessment of prostate size (MEN) • Constipation • Voiding difficulty • Retention of urine • Not documented	NOT DOCUMENTED scores 0 ONE OR MORE INDICATION scores 1
2.11	Is there documented evidence that a rectal examination was performed?	YES scores 1, NO scores 0, NO BUT scores 1
2.12	Is there documented evidence of urinalysis?	YES scores 1, NO scores 0
	Focused Examination	
2.14	Is there documented evidence that a focused examination has been performed?	
2.15	Is there documented evidence of the following?	Q2.14YES & Q2.15 Three/Four elements scores 2 Q2.14YES & Q2.15 One/Two elements scores 1 Q2.14YES & Q2.15 No elements scores 0 Q2.14NO scores 0 Q2.15NoBut counts as YES
2.15i **2.15ii** **2.15iii** **2.15iv**	• Examination of the abdomen for palpable mass or bladder retention • Examination to assess pelvic floor dysfunction • Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy (WOMEN) • Rectal examination to exclude faecal loading/prostate size	
	INVESTIGATIONS	
	Initial Assessment	
2.17	Is there documented evidence of: • Urea & Electrolytes • GFR (without indication of renal impairment) • Cystoscopy • Abdominal Ultrasound • Abdominal X-ray • Flow Rate • Post void residual volume (PVRD)	PVRD ALONE scores 0 NONE OF ABOVE scores 0 ANY OTHER FACTOR (IRRESPECTIVE OF WHETHER PVRD ALSO APPLIES) scores -1 MAXIMUM SCORE DEDUCTED scores -1
2.24	Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment?	YES scores minus 1, NO scores 1 NOT DOCUMENTED scores 0 RECORDS NOT AVAILABLE ON SITE scores 0 No conservative treatment / records not available for Q2.23 scores 0
2.26	For women with monosymptomatic stress urinary incontinence, is there documented evidence of the use of multi-channel cystometry **prior to** surgery? WOMEN	YES scores minus 1, NO scores 1 RECORDS NOT AVAILABLE ON SITE scores 0 Did not have monosymptomatic stress urinary incontinence scores 0
2.28	Is there documented evidence of a clear identification of the type/cause of urinary incontinence?	YES scores 1, NO scores 0
3	**MANAGEMENT**	
	Treatment	
3.2	Did the patient have a treatment plan?	YES scores 1, NO scores 0
3.14	Did the patient suffer from Stress Urinary Incontinence WOMEN	Q3.14 NO SUI scores 0
3.14i	For the treatment of SUI in women is there documented evidence of the use of: WOMEN	**Q3.14i For SUI only:** Use of anterior colporrhaphy, needle suspension, paravaginal

	1. Anterior colporrhaphy 2. Needle suspension 3. Paravaginal defect repair 4. Marshall- Marchetti – Krantz procedure (MMK) • Autologous fat /PTFE injections • Mid Urethral Tape • Colpo suspension • Autologous rectus fascial sling	defect repair or , MMK scores -1 NO TO ALL 4 scores 0 YES TO ANY OF THE 4 scores -1 'RECORDS NOT AVAILABLE ON SITE' TO BE SCORED AS 'NO' Others don't count in the scoring system
	Containment	
3.16	Is there documented evidence of the indication for indwelling catheterisation as a form of management?	YES scores 1, NO scores 0
4	**Care Plan and communication**	
4.1 **4.1i**	Does the patient have a documented continence care plan? **If yes**, when was the patient's care plan last reviewed? Less than 6 months 6-8 months 9-11 months 12 months or more	4.1NO scores 0 4.1YES & <9M scores 2 4.1YES & >=9M scores 1 4.1YES & NO DOCUMENTATION scores 0
4.5	Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient?	YES scores 1, NO scores 0 NO BUT scores 1
4.6	Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? **Over 65**	YES scores 1, NO scores 0 NO BUT scores 1
	Communication / Information	
4.7	Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence?	YES scores 1, NO scores 0 NO BUT scores 1
4.8	Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? **Over 65**	YES scores 1, NO scores 0 NO BUT scores 1

APPENDIX 4: THE SCORING SYSTEM FOR BOWEL AUDIT CASES

The score can range from 0 to 23 for persons aged 65 years and over and from 0 to 21 for persons younger than 65 years. This appendix indicates which questions have been included in the scoring system and explains the scoring or weighting given to each item. These scores were developed using the nominal group method, following two rounds of scoring, by members of the NACC working party. The mechanics of the scoring system following identification of the standards to be included was developed by the lead for the project and the project statistician in consultation with the working party.

QUESTIONS		Score
1. **1.1**	**Symptoms** How often is the patient incontinent of faeces? • Every day/night • Less than once weekly • More than once weekly • Not documented • Not known	 NOT DOCUMENTED scores 0 NOT KNOWN scores 1 FREQUENCY KNOWN scores 2
2	**Assessment**	
2.1 **2.1i**	Is there documented evidence of a bowel history? If yes, does the history of faecal incontinence include: • Duration of symptoms • Daytime symptoms • Nocturnal symptoms	2.1NO scores 0 2.1YES & 2.1iYES/NO to any symptom option scores 2 2.1YES & 2.1iNOT DOCUMENTED/RECORDS NOT AVAILABLE for all options scores 1
2.2	Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence?	YES scores 1, NO scores 0
2.4	Is the patient on medication that exacerbates faecal incontinence?	YES scores 1, NO scores 0 NOT DOCUMENTED scores 0
2.4i	Has this medication been altered to minimise its impact?	2.4i YES scores 1, NO scores 0 NOT DOCUMENTED scores 0 NOT ABLE TO MINIMISE FURTHER scores 1
2.5	Is there evidence that the impact of symptoms on quality of life have been recorded?	YES scores 1, NO scores 0, NO BUT scores 1
2.6	**Cognitive Status** (Over 65 cohort only)	
2.6	Has the patient's cognition been assessed?	YES scores 1, NO scores 0 NOT DOCUMENTED scores 0
2.6ii	Is there documented use of a formal scoring system for assessment of cognition?	YES scores 1, NO scores 0
2.7	**Functional Status**	
2.7	Has the patient's functional ability been assessed?	YES scores 1, NO scores 0 NOT DOCUMENTED scores 0
2.7ii	Is there documented use of a formal scoring system for assessment?	YES scores 1, NO scores 0
	Examination	
	Basic examination	
2.8	Is there documented evidence of rectal examination to exclude faecal loading?	YES scores 1, NO scores 0, NO BUT scores 1
	Focused examination	
2.9 **2.9iib** **2.9iic** **2.9iid**	Is there documented evidence that a focused examination has been performed? • Examination of abdomen for palpable mass bladder retention • Examination of perineum and anus. • Rectal examination	2.9NO scores 0 2.9YES & YES to all 3 options scores 2 2.9YES & YES to 0-2 options scores 1 'NOT REQUIRED' scores as 'YES'
2.11	Is there documented evidence of a clear identification of the types or causes of bowel problem?	YES scores 1, NO scores 0 NO BUT scores 1
3	**Treatment**	
  3.1i **3.1ii** **3.1iii** **3.1iv** **3.1v**	Is there documented evidence that **condition-specific intervention** has been given or planned for the following: • Faecal loading? • Potentially treatable causes of diarrhoea? • Rectal prolapse or third-degree haemorrhoids? • Acute anal sphincter injury? • Acute disc prolapse/cauda equina syndrome?	 3-5 conditions scores 2 1-2 conditions scores 1 NONE scores 0 'NOT APPLICABLE' counts as 'YES'
3.2	Are the patient's goals for treatment recorded?	YES scores 1, NO scores 0,

		NO BUT scores 1
3.7 3.7i 3.7ii 3.7iii 3.7iv 3.7v 3.7vi 3.7vii	Is there documented evidence that long-term management of Faecal Incontinence has been given or planned? • Advice and information on continence products • Advice on skin care • Advice relating to preservation of dignity • Advice relating to preservation of independence • Contact details for relevant support groups • Periodic review of symptoms • Psychological and emotional support	Scores 1 for any of 3.7i-3.7vii answered YES Score scores 0 for section entirely consisting of NO/Not required answers
	Containment	
4	**Care Plan / communication**	
4.1	Does the patient have a documented continence care plan?	YES scores 1, NO scores 0
4.2	Is there documented evidence that a copy of the care plan has been given to the patient?	YES scores 1, NO scores 0, NO BUT scores 1
	Communication / Information	
4.4	Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem?	YES scores 1, NO scores 0, NO BUT scores 1

APPENDIX 5: Proformas

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2010

Commissioning Audit Proforma

(one to be completed per site, please complete all questions)

Your Site Code

Instructions for completion:
1. Please use a black or blue pen for all sections.
2. Please cross the boxes as appropriate (☒ or ☒).

If you are unclear of any questions on this form please use the accompanying *help booklet*.

All enquires should be sent, quoting your site code, to:
Tel: 020 3075 1347 / 020 3075 1619 / 020 3075 1511 or e-mail: nacc@rcplondon.ac.uk

1. Commissioning Continence Services

1.1 Are you aware of the Department of Health guidelines for good practice in continence services? ○ Yes ○ No ***(If YES go to 1.2)***

1.1i **If NO**, why not?

1.2 Do you ensure that the service which you commission includes:

1.2i Director of Continence services or head of services with responsibility for policy? ○ Yes ○ No

1.2ii Clear referral pathways for patients between Providers? ○ Yes ○ No

1.3 Do you currently commission according to NICE guidelines and the accompanying toolkits for this purpose? ○ Yes ○ No ***(If YES go to 1.4)***

1.3i **If NO**, why not?

1.4 Who provides community continence services (continence advisory service) within your area? (select all that apply)

- ○ GP
- ○ Acute Trust
- ○ Private provider of NHS services
- ○ Alternative provider organisation
- ○ Social enterprise
- ○ Primary care provider
- ○ Other (please specify)

1.5 How are hospital continence services commissioned?

- ○ Block contract for activity
- ○ Within existing urology/ urogynaecology services
- ○ As for community service
- ○ Other (please specify)

1.6 Do you have any existing non- financial performance indicators for quality in continence care for the services you commission? ○ Yes ○ No

If yes please could you specify the nature of these?

1.7 Do you currently use (CQUINS) Commissioning for Higher Quality and Innovation as part of your performance management criteria for these services? ○ Yes ○ No

Royal College of Physicians
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National Audit of Continence Care 2010

Organisational Audit Proforma

(one to be completed per site, please complete all questions)

Your Site Code

Instructions for completion:
3. Please use a ball-point pen for all sections.
4. Please cross the boxes as appropriate (☒ or ☒).

If you are unclear of any questions on this form please use the accompanying *help booklet*.

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1. POLICIES AND PROCEDURES

1.1 Does the facility (GP practice/ hospital /care home), or the continence service covering the facility, have a **written policy** for the management of continence? ○ Yes ○ No ***(If NO go to 1.2)***

If yes, does this policy include:

1.1i Training for staff in continence care ○ Yes ○ No

1.1ii Assessment and treatment of incontinence ○ Yes ○ No

1.1iii A means for regular audit of continence services ○ Yes ○ No

1.2 Does the continence service to which patients have access accept self referrals? ○ Yes ○ No

1.3 What is the nature of the current provider of NHS continence care to which patients have access? (select all that apply)

- ○ Community provider
- ○ Hospitals service
- ○ Alternative provider organisation
- ○ Primary care network
- ○ Private provider of NHS services
- ○ Not known
- ○ Other (specify) _____

1.4 Are there local plans to change the provision of NHS services away from the current provider? ○ Yes ○ No

1.5 Does the facility utilise an Integrated care pathway or an evidence based treatment algorithm for patients with incontinence? (select all that apply)

- ☐ Integrated care pathway
- ☐ Algorithm
- ☐ Care plan
- ☐ None of these

1.6 Does the facility submit surgical audit data to the ○ Yes ○ No ○ Not applicable

relevant specialist society database?

2. SCREENING

2.1 Is it the facility's practice to ask a screening question relating to bladder and bowel problems as part of the initial assessment? ○ Yes ○ No

2.2 Is there a written protocol for providing a basic assessment for all people who indicate that they have problems with urinary and/or faecal continence? ○ Yes ○ No

2.3 Does the facility routinely use a standardised measure to record functional ability for older patients (e.g. Barthel/MDS-RAI)? ○ Yes ○ No

2.4 Does the facility routinely use a standardised measure to record mental state e.g. Abbreviated Mental Test Score, Mini-Mental State Examination)? ○ Yes ○ No

2.5 Does the facility routinely use a clinically defined measure of severity of symptoms? ○ Yes ○ No

2.6 Does the clinical team include a practitioner who has had training to:

2.6i take a continence history? ○ Yes ○ No ☐ Dr ☐ Nurse ☐ Physio ☐ Other

2.6ii initiate a frequency-volume chart? ○ Yes ○ No Specify the practitioner ☐ Dr ☐ Nurse ☐ Physio ☐ Other

2.6iii perform a rectal examination? ○ Yes ○ No (select all that apply) ☐ Dr ☐ Nurse ☐ Physio ☐ Other

2.6iv perform a urinalysis? ○ Yes ○ No ☐ Dr ☐ Nurse ☐ Physio ☐ Other

3. STAFF

3.1 Does the facility have access to an integrated continence service? (as defined by "Good Practice in continence services") (DoH 2000) (See Help Notes) ○ Yes ○ No ***(if NO go to 3.2)***

3.1i **If yes**, does the service have: (select all that apply)

- ☐ Director of integrated services
- ☐ Lead of integrated services
- ☐ Continence nurse specialists
- ☐ Specialist continence physiotherapists
- ☐ Specialist continence occupational therapists
- ☐ Unable to find the information from my local service

3.1ii **If yes,** does this service have designated referral pathways with: (select all that apply):

- ☐ Gynaecology (including Urogynaecology)
- ☐ Colorectal surgery
- ☐ Urology
- ☐ Gastroenterology
- ☐ Geriatric Medicine
- ☐ Neurology

☐ Community continence Service

☐ Via GP specialist consultant

☐ None of the above

☐ Unable to find the information from my local service

If you are a care home or Mental Health Trust go to Q 3.4

3.2 Do the surgeons operating on people with urinary incontinence work as part of the multidisciplinary team? (see help notes) ○ Yes ○ No

3.3 Is there a designated clinical surgical lead for continence and prolapse surgery within the unit? (see help notes) ○ Yes ○ No

3.4 Does your local service have investigation and treatment facilities, which include access to: (select all that apply)

☐ Urodynamics

☐ Urinary or gastrointestinal tract imaging

☐ Anorectal physiology

☐ Unable to find the information from my local service

☐ None of the above

4. TRAINING

4.1 Is there a structured **programme of staff training** on promoting continence for the facility? ○ Yes ○ No ***(If NO go to 4.2)***

4.1i **If yes**, does the **programme** include basic assessment? (i.e. all of these: history taking, urinalysis, rectal examination and frequency/volume charting) ○ Yes ○ No

4.1ii Does the service use any of the National Occupational Standards (Continence Care) to guide the content of its training? ○ Yes ○ No ○ Not aware of these

4.1iii Does the service use any of the National Occupational Standards (Continence Care) to develop work based competency packages? ○ Yes ○ No

4.2 Do patients have access to a local continence practitioner, who is able to give advice on continence, and bladder and bowel care? ○ Yes ○ No ***(If NO go to 4.3)***

4.2i **If yes**, is the practitioner: (select all that apply)

○ Hospital based

○ Community based

○ Not known

4.3 Is a specialist continence assessment always carried out by a practitioner with training in? (select all that apply)

☐ Knowledge of the aetiology of urinary and faecal incontinence

☐ Experience in taking a history

☐ Ability to carry out an abdominal examination

☐ Ability to carry out a rectal examination

☐ Ability to carry out a vaginal examination

☐ Ability to perform urinalysis

☐ Ability to carry out residual volume measurement

☐ None of the above

☐ Not known

4.4 What is the number of whole time equivalent continence practitioners available to you?

PCT ☐ ○ Not known

Hospital service ☐ ○ Not known

5. ENVIRONMENT

5.1 Do the areas for both assessment AND treatment of patients with bladder and bowel problems preserve the patient's privacy and dignity according to current standards? (for guidance see help notes) ○ Yes ○ No ***(If YES go to 5.1ii)***

5.1i **If No**, what are your areas of concern?

5.1ii **If you have ticked Yes**, which of the following does this include: (select all that apply)

- ☐ Privacy around the bed area
- ☐ Privacy around the toilet area
- ☐ Easily accessible toilet facilities
- ☐ Appropriate aids to toileting (frames/rails etc)
- ☐ Privacy when staff speak to in-patients in confidence
- ☐ Privacy when staff speak to out-patients in confidence
- ☐ Steps taken to reduce odour
- ☐ Hand washing after toileting
- ☐ Other, please specify: ☐

6. USER EVALUATION OF THE SERVICE

6.1 Are there means in the care setting by which continence service users/patients can make:

6.1i Suggestions ○ Yes ○ No

6.1ii Complaints ○ Yes ○ No

6.2 Is the bladder or bowel care delivered by the service subject to regular audit? ○ Yes ○ No ○ Not known ***(If NO go to 6.3)***

6.2i **If yes**, does the audit assess the patient's concern regarding privacy and dignity? ○ Yes ○ No ○ Not known

6.3 Does the continence service have a user group? ○ Yes ○ No ○ Not known ***(If NO go to 6.4)***

6.3i **If yes**, is this group involved in service planning and delivery? ○ Yes ○ No

6.3ii Is this group a support group? ○ Yes ○ No

6.4 Does the continence service have a system in place ○ Yes ○ No ○ Not known

for the review of any complaints made by the users/patients?

7. CONTINENCE PRODUCTS

7.1 To which NHS continence products do patients / residents have access? (select all that apply)

- ☐ Body worn pads (disposable)
- ☐ Body worn pads (re-usable)
- ☐ All-in-one disposable
- ☐ All-in-one (re-usable)
- ☐ Reusable products (pants)
- ☐ Other, please specify

7.2	Does your **written policy** indicate that products are supplied on the basis of clinical and patient need rather than cost?	○ Yes ○ No ○ Not known
7.3	Are patients'/carers' views sought in selecting the range of products to be supplied?	○ Yes ○ No ○ Not known
7.4	Is there a written policy for eliciting patient/carer views?	○ Yes ○ No ○ Not known
7.5	Do you have a limit on the type of products supplied per day?	○ Yes ○ No ○ Not known **(If NO or Not Known go to 7.6)**
7.5i	What is the minimum number of products supplied per day?	☐ ○ Not applicable
7.5ii	What is the maximum number of products supplied per day?	☐ ○ No maximum limit
7.5iii	Who is responsible for the imposition of this limit? (choose one option only)	○ Local community service ○ Care home provider ○ Hospital trust ○ Local authority
7.6	Who normally provides additional products? (select all that apply)	☐ The patient/ resident ☐ Family ☐ Care home ☐ Other (please specify) ☐ None required ☐ Not Know

8. PATIENT/CARER INFORMATION AND SUPPORT

8.1	Is evidence-based information about bladder and bowel care freely available to patients and carers?	○ Yes, all areas ○ Yes, some areas ○ No ○ Not known

8.2	Does the facility utilise patient information literature e.g. from charities to promote continence?	○ Yes ○ No ○ Not known

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2010

Clinical Proforma for Bladder Problems – Urinary Incontinence

Please answer ALL questions (one proforma to be completed per patient/resident)

Your Site Code

[ ]

WOMEN ONLY

Instructions for completion:
5. Please use a ball-point pen for all sections.
6. Please cross the boxes as appropriate (☒ or ☒).

If you are unclear of any questions on this form please use the accompanying *help booklet*.

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AUDITOR DISCIPLINE

Select main discipline for this case: ○ Doctor ○ Nurse ○ Therapist ○ Manager ○

Other [ ]

DEMOGRAPHIC INFORMATION

A. Patient audit number [ ]

B. Age (Years) [ ]

C. Sex ○ Male ○ Female

D. Ethnicity: ○ White British ○ Other ○ Not recorded

E. Is English the primary language of the patient? ○ Yes ○ No ○ Not known ○ Not documented

F. Please indicate in which care setting this patient is in? (choose one only)

○ Care home (residential and nursing)
○ Community dwelling in-patient
○ In-patient of primary care trust run hospital
○ Patient of acute trust hospital
○ Patient of local continence service
○ other (please specify):

[ ]

1. SYMPTOMS

1.1 Does the patient have: (please answer all questions)

		Condition documented as:			
		Present	Absent	Not documented	Records not available on site
1.1i	Nocturnal frequency (>2 voids /night)	○	○	○	○
1.1ii	Urinary frequency (>8 voids/24h)	○	○	○	○
1.1iii	Nocturnal enuresis	○	○	○	○
1.1iv	Urinary urgency	○	○	○	○
1.1v	Urgency (urge) incontinence	○	○	○	○
1.1vi	Stress urinary incontinence (urine loss with coughing, straining, exertion)	○	○	○	○
1.1vii	This option is for men only and does not appear.				
1.1viii	Clinically significant post void residual volume	○	○	○	○
1.1ix	Voiding difficulty	○	○	○	○
1.1x	Intermittent catheter	○	○	○	○
1.1xi	Permanent catheter	○	○	○	○
1.1xii	Constipation	○	○	○	○
1.1xiii	Bladder pain	○	○	○	○

1.2 What other relevant documented conditions does the patient have either currently or in the past? (select all that apply)

- ☐ Bladder cancer/stones
- ☐ Chronic cough
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Faecal loading or chronic constipation
- ☐ Heart failure
- ☐ Hypertension
- ☐ Impaired mobility
- ☐ Neurological disease
- ☐ Obesity
- ☐ Urogenital atrophy
- ☐ Pelvic radiotherapy
- ☐ Pelvic surgery e.g. hysterectomy
- ☐ Prolapse
- ☐ Recurrent falls
- ☐ Spinal cord disease/trauma
- ☐ Smoking
- ☐ Stroke
- ☐ Trauma at childbirth
- ☐ Acute urinary tract infection
- ☐ Other (please specify)

  [ ]
- ☐ No documentation of the above

1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence? (select all that apply) (See help notes for guidance)

- ☐ Stress urinary incontinence
- ☐ Mixed urinary incontinence
- ☐ Passive leakage
- ☐ Urgency urinary Incontinence
- ☐ Detrusor overactivity / overactive bladder)
- ☐ Functional (see help notes)
- ☐ Urinary tract infection
- ☐ Voiding difficulty
- ☐ Urogenital atrophy
- ☐ Other (please specify)

  [ ]
- ☐ No diagnosis documented

Cognitive status

1.4 Has the patient's cognition been assessed? (see help notes for guidance)
○ Yes ○ No ○ Not documented
(If YES answer ALL / If NO or Not documented answer 1.4i and proceed to 1.5)

1.4i Is the patient's cognitive status: (see help notes for guidance)
○ Unimpaired ○ Mild ○ Moderate ○ Severe
○ Insufficient information to calculate

1.4ii Is there documented use of a formal scoring system for assessment of cognition? (see help notes for guidance)
○ Yes ○ No

Functional status

1.5 Has the patient's functional ability been assessed? (see help notes for guidance)
○ Yes ○ No ○ Not documented
(If YES answer ALL / If NO or Not documented answer 1.5i and proceed to 2)

1.5i Is the patient's functional status: (see help notes for guidance)
○ Unimpaired ○ Mild ○ Moderate ○ Severe
○ Insufficient information to calculate

1.5ii Is there documented use of a formal scoring system for assessment of functional ability? (see help notes for guidance)
○ Yes ○ No

2. ASSESSMENT, EXAMINATION AND INVESTIGATIONS

ASSESSMENT

History

2.1 Is there documented evidence of a continence history?
○ Yes ○ No ***(if NO go to 2.2)***

2.1i **If yes,** does the history of urinary incontinence include:

Daytime symptoms ○ Yes ○ No ○ Not documented ○ Records not available on site

Nocturnal symptoms ○ Yes ○ No ○ Not documented ○ Records not available on site

2.2 Is the patient incontinent of faeces?
○ Yes ○ No

2.3 Is the patient's bowel habit documented?
○ Yes ○ No

2.4 Is there evidence of the use of a three day bladder diary?
○ Yes ○ No ○ ***No, but*** the patient is incompetent to use a chart/diary

2.5 Is there documented evidence of the use of
○ Yes ○ No ○ ***No, but*** the patient is

any bladder diary? | incompetent to use a chart/diary

2.6 Is the patient on medication that may exacerbate urinary incontinence? ○ Yes ○ No ***(if NO go to 2.7)***

2.6i Has this medication been altered to minimise its impact? ○ Yes ○ No ○ Not able to minimise further

2.7 Is there documented evidence that the impact of symptoms on quality of life has been assessed? ○ Yes ○ No ○ ***No, but*** patient is mentally incompetent to undergo assessment

2.8 Is there documented evidence that the impact of symptoms on quality of life has been recorded using a standard assessment scale? ○ Yes ○ No ○ ***No, but*** patient is mentally incompetent to undergo assessment

---

EXAMINATION

Basic examination

(for guidance on what constitutes "basic examination" see help notes)

2.10 Is there a documented indication for rectal examination? (select all that apply)
- ○ Constipation
- ○ Voiding difficulty
- ○ Retention of urine
- ○ Not documented

2.11 Is there documented evidence that a rectal examination was performed? ○ Yes ○ No, ○ **No, but** consent could not be gained

2.12 Is there documented evidence of urinalysis? ○ Yes ○ No

2.13 Is there documented evidence of a mid stream specimen of urine being sent? ○ **Yes** ○ **No** ○ **No, but patient is distressed or too agitated?**

Focused examination

(for guidance on what constitutes a "focused examination" see help notes)

2.14 Is there documented evidence that a focused examination has been performed? ○ Yes ○ No ***(if NO go to 2.15)***

2.14i **If yes**, who has performed the examination? (Select all that apply)

- ○ Geriatrician
- ○ GP
- ○ Gynaecologist
- ○ Nurse
- ○ Therapist
- ○ Hospital ward based doctor
- ○ Urologist
- ○ Other (please specify) _____

2.15 Is there documented evidence of the following?

2.15i Examination of the abdomen for palpable mass or bladder retention ○ Yes ○ No

2.15ii Examination to assess pelvic floor dysfunction ○ Yes ○ No

2.15iii Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy ○ Yes ○ No

2.15iv Rectal examination to exclude faecal loading/prostate size ○ Yes ○ No ○ **No, but** consent could not be gained

2.16 Is there documented evidence that a woman with a symptomatic prolapse extending to the introitus was referred for a specialist opinion?
○ Yes ○ No ○ **No, but** consent could not be gained
○ No prolapse present

INVESTIGATIONS

Initial Assessment

2.17 Is there documented evidence of:
(select all that apply)

☐ Urea & Electrolytes
☐ GFR (without indication of renal impairment)
☐ Cystoscopy
☐ Abdominal Ultrasound
☐ Abdominal X-ray
☐ Flow Rate
☐ Post void residual volume
☐ None of the above

2.18 Is there documented evidence of measurement of post-void residual volume (PVR) using ultrasound or catheterisation?
○ Yes ○ No ○ ***No, but*** consent was unobtainable.
(see help notes for guidance)

2.19 Is there documented evidence of the use of a pad test for routine assessment?
○ Yes ○ No

Specialised Assessment

2.21 Is there documented use of routine imaging (CT / MRI / X-ray / ultrasound) for routine assessment?
○ Yes ○ No ○ Records not available on site

2.22 In routine assessment is there documented evidence of the use of:

Q-tip test	○ Yes	○ No	○ Records not available on site
Bonney's test	○ Yes	○ No	○ Records not available on site
Fluid bridge test	○ Yes	○ No	○ Records not available on site
Cystoscopy	○ Yes	○ No	○ Records not available on site

URODYNAMIC TESTING (CYSTOMETRY)

2.23 Did the patient have conservative treatment?
If no go to 2.25 if yes go to 2.24
○ Yes ○ No ○ Records not available on site

2.24 Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment? (see help notes for guidance)
○ Yes ○ No ○ Records not available on site
○ Not documented

2.25 Did the patient have surgery or is it documented that they are considering surgery?
○ Yes ○ No ○ Records not available on site

2.26 For women with monosymptomatic stress urinary incontinence, is there documented evidence of the use of multi-channel cystometry **prior to** surgery?
○ Yes ○ No ○ Records not available on site
○ Did not have monosymptomatic stress urinary incontinence

Diagnosis

2.28 Is there documented evidence of a clear
○ Yes ○ No

identification of the type/cause of urinary incontinence?

3. MANAGEMENT

Treatment

3.1 Did the patient require treatment? ○ Yes ○ No

3.2 Did the patient have a treatment plan? ○ Yes ○ No

If you answered 'NO' to both 3.1 & 3.2 go to 3.4 otherwise answer 3.3

3.3 Which of the following methods of treatment have been used or are planned? (select all that apply)

	Used	Planned	Neither Used or Planned	
3.3i				Lifestyle modification
3.3ii				Behavioural modification
3.3iii				Bladder training regimes (supervised)
3.3iv				Containment
3.3v				Electrical stimulation (incl. afferent nerve stimulation)
3.3vi				Management of faecal impaction
3.3vii				Topical oestrogen treatment
3.3viii				Pelvic floor training (supervised and of minimum three months duration)
3.3ix				Review of medication
3.3x				Toileting schedules
3.3xi				Treatment of co-morbidities
3.3xii				Treatment of acute urinary tract infection
3.3xvi				Other (please specify)

Pharmacological interventions

3.10 Is there documented evidence that proprietary, immediate release oxybutynin was used as the first line treatment for women with a diagnosis of overactive bladder syndrome?
○ Yes ○ No ○ ***No, but*** it is documented that either the woman has tried this medication previously or there is a contraindication to this prescription
○ Did not have an overactive bladder

3.11 Is there documented evidence of the use of duloxetine for the treatment of women with Stress Urinary Incontinence?
○ Yes ○ No ○ Did not have stress urinary incontinence

3.12 Is there documented use of either probantheline, flavoxate or imipramine?
○ Yes ○ No

Surgery

3.14 Did the Patient suffer from Stress Urinary ○ Yes ○ No ○ Records not available on site

Incontinence?
(If YES go to 3.14i if NO go to 3.15)

3.14i For the treatment of SUI in women is there documented evidence of the use of:

Anterior colporrhaphy	○ Yes	○ No	○ Records not available on site
Needle suspension	○ Yes	○ No	○ Records not available on site
Paravaginal defect repair	○ Yes	○ No	○ Records not available on site
Marshall- Marchetti – Krantz procedure	○ Yes	○ No	○ Records not available on site
Autologous fat /PTFE injections	○ Yes	○ No	○ Records not available on site
Mid Urethral Tape	○ Yes	○ No	○ Records not available on site
Colpo suspension	○ Yes	○ No	○ Records not available on site
Autologous rectus fascial sling	○ Yes	○ No	○ Records not available on site

---

CONTAINMENT

3.15 Which of the following methods of containment have been used or are planned for treatment? (select all that apply)

- ☐ Body worn pads (disposable)
- ☐ Body worn pads (re-usable)
- ☐ All-in-one disposable
- ☐ All-in-one (re-usable)
- ☐ Reusable products (pants)
- ☐ Bed protection
- ☐ Indwelling catheter
- ☐ Intermittent catheterisation
- ☐ Devices (see help notes for guidance)
- ☐ Containment not part of care plan
- ☐ Not documented
- ☐ Other (please specify)

3.16 Is there documented evidence of the indication for indwelling catheterisation as a form of management? ○ Yes ○ No

3.17 Is there documented evidence of the arrangement for provision of maintenance products on discharge from hospital? ○ Yes ○ No ○ Not applicable

(Hospitalised patients only)

3.17i **Is this: (choose one only)**

- ☐ Patient to buy products
- ☐ Limited supply from hospital followed by own supply
- ☐ Limited supply from hospital followed by NHS supply
- ☐ No supply from hospital with an arrangement for NHS supply

4. CARE PLAN / REVIEW / COMMUNICATION

4.1 Does the patient have a documented continence care plan? ○ Yes ○ No ***(if NO go to 4.5)***

4.1i **If yes,** when was the patient's care plan last reviewed?

- ○ Less than 6 months
- ○ 6-8 months
- ○ 9-11 months

○ 12 months or more
○ No documentation of reassessment

4.5	Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient?	○ Yes	○ No	○ ***No, but*** the patient lacks mental capacity.
4.6	Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative?	○ Yes	○ No	○ ***No, but*** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.

COMMUNICATION / INFORMATION

4.7	Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence?	○ Yes	○ No	○ ***No, but*** the patient is incompetent to participate in such discussion
4.8	Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative?	○ Yes	○ No	○ ***No, but*** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2010

Clinical Proforma for Bladder Problems – Urinary Incontinence

Please answer ALL questions (one proforma to be completed per patient/resident)

Your Site Code

☐

MEN ONLY

Instructions for completion:
7. Please use a ball-point pen for all sections.
8. Please cross the boxes as appropriate (☒ or ☒).

If you are unclear of any questions on this form please use the accompanying *help booklet*.

All enquires should be sent, quoting your site code, to:
Tel: 020 3075 1347 / 020 3075 1619 / 020 3075 1511 or e-mail: nacc@rcplondon.ac.uk

AUDITOR DISCIPLINE

Select main discipline for this case: ○ Doctor ○ Nurse ○ Therapist ○ Manager ○ Other ☐

DEMOGRAPHIC INFORMATION

A. Patient audit number ☐

B. Age (Years) ☐

C. Sex ○ Male ○ Female

D. Ethnicity: ○ White British ○ Other ○ Not recorded

E. Is English the primary language of the patient? ○ Yes ○ No ○ Not known ○ Not documented

F. Please indicate in which care setting this patient is in? (choose one only)

○ Care home (residential and nursing)
○ Community dwelling in-patient
○ In-patient of primary care trust run hospital
○ Patient of acute trust hospital
○ Patient of local continence service
○ other (please specify): ☐

1. SYMPTOMS

1.1 Does the patient have: (please answer all questions)

		Condition documented as:			
		Present	Absent	Not documented	Records not available on site
1.1i	Nocturnal frequency (>2 voids /night)	○	○	○	○
1.1ii	Urinary frequency (>8 voids/24h)	○	○	○	○
1.1iii	Nocturnal enuresis	○	○	○	○
1.1iv	Urinary urgency	○	○	○	○
1.1v	Urgency (urge) incontinence	○	○	○	○
1.1vi	Stress urinary incontinence (urine loss with coughing, straining, exertion)	○	○	○	○
1.1vii	Post micturition dribble	○	○	○	○
1.1viii	Clinically significant post void residual volume	○	○	○	○
1.1ix	Voiding difficulty	○	○	○	○
1.1x	Intermittent catheter	○	○	○	○
1.1xi	Permanent catheter	○	○	○	○
1.1xii	Constipation	○	○	○	○
1.1xiii	Bladder pain	○	○	○	○

1.2 What other relevant documented conditions does the patient have either currently or in the past? (select all that apply)

- ☐ Bladder cancer/stones
- ☐ Chronic cough
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Faecal loading or chronic constipation
- ☐ Heart failure
- ☐ Hypertension
- ☐ Impaired mobility
- ☐ Neurological disease
- ☐ Obesity
- ☐ Pelvic radiotherapy
- ☐ Prostate disease or surgery
- ☐ Recurrent falls
- ☐ Spinal cord disease/trauma
- ☐ Smoking
- ☐ Stroke
- ☐ Acute urinary tract infection
- ☐ Other (please specify)

  [ ]

- ☐ No documentation of the above

1.3 Is there documented evidence of a clear indication of the type/cause of urinary incontinence? (select all that apply) (See help notes for guidance)

- ☐ Stress urinary incontinence
- ☐ Mixed urinary incontinence
- ☐ Passive leakage
- ☐ Urgency urinary Incontinence
- ☐ Detrusor overactivity / overactive bladder
- ☐ Functional (see help notes)
- ☐ Urinary tract infection
- ☐ Voiding difficulty
- ☐ Other (please specify)
- ☐ No diagnosis documented

Cognitive status

1.4 Has the patient's cognition been assessed? (see help notes for guidance)
○ Yes ○ No ○ Not documented
(If YES answer ALL / If NO or Not documented answer 1.4i and proceed to 1.5)

1.4i Is the patient's cognitive status: (see help notes for guidance)
○ Unimpaired ○ Mild ○ Moderate ○ Severe
○ Insufficient information to calculate

1.4ii Is there documented use of a formal scoring system for assessment of cognition? (see help notes for guidance)
○ Yes ○ No

Functional status

1.5 Has the patient's functional ability been assessed? (see help notes for guidance)
○ Yes ○ No ○ Not documented
(If YES answer ALL / If NO or Not documented answer 1.5i and proceed to 2)

1.5i Is the patient's functional status: (see help notes for guidance)
○ Unimpaired ○ Mild ○ Moderate ○ Severe
○ Insufficient information to calculate

1.5ii Is there documented use of a formal scoring system for assessment of functional ability? (see help notes for guidance)
○ Yes ○ No

2. ASSESSMENT, EXAMINATION AND INVESTIGATIONS

ASSESSMENT

History

2.1 Is there documented evidence of a continence history?
○ Yes ○ No ***(if NO go to 2.2)***

2.1i **If yes,** does the history of urinary incontinence include:

Daytime symptoms ○ Yes ○ No ○ Not documented ○ Records not available on site

Nocturnal symptoms ○ Yes ○ No ○ Not documented ○ Records not available on site

2.2 Is the patient incontinent of faeces?
○ Yes ○ No

2.3 Is the patient's bowel habit documented?
○ Yes ○ No

2.5 Is there documented evidence of the use of
○ Yes ○ No ○ ***No, but*** the patient is

any bladder diary? | | incompetent to use a chart/diary

2.6 Is the patient on medication that may exacerbate urinary incontinence? ○ Yes ○ No ***(if NO go to 2.7)***

2.6i Has this medication been altered to minimise its impact? ○ Yes ○ No ○ Not able to minimise further

2.7 Is there documented evidence that the impact of symptoms on quality of life has been assessed? ○ Yes ○ No ○ ***No, but*** patient is mentally incompetent to undergo assessment

2.9 Is there evidence of the use of a validated symptom score at initial assessment? ○ Yes ○ No ○ ***No, but*** patient is mentally incompetent to undergo assessment

---

EXAMINATION

Basic examination

(for guidance on what constitutes "basic examination" see help notes)

2.10 Is there a documented indication for rectal examination? (select all that apply)
- ○ Assessment of prostate size
- ○ Constipation
- ○ Voiding difficulty
- ○ Retention of urine
- ○ Not documented

2.11 Is there documented evidence that a rectal examination was performed? ○ Yes ○ No, ○ **No, but** consent could not be gained

2.12 Is there documented evidence of urinalysis? ○ Yes ○ No

2.13 Is there documented evidence of a mid stream specimen of urine being sent? ○ **Yes** ○ **No** ○ No, but **patient is distressed or too agitated?**

Focused examination

(for guidance on what constitutes a "focused examination" see help notes)

2.14 Is there documented evidence that a focused examination has been performed? ○ Yes ○ No ***(if NO go to 2.15)***

2.14i **If yes**, who has performed the examination? (Select all that apply)

- ○ Geriatrician
- ○ GP
- ○ Nurse
- ○ Therapist
- ○ Hospital ward based doctor
- ○ Urologist
- ○ Other (please specify) _____

2.15 Is there documented evidence of the following?

2.15i Examination of the abdomen for palpable mass or bladder retention ○ Yes ○ No

2.15ii Examination to assess pelvic floor dysfunction ○ Yes ○ No

2.15iv Rectal examination to exclude faecal loading/prostate size ○ Yes ○ No ○ **No, but** consent could not be gained

INVESTIGATIONS

Initial Assessment

2.17 Is there documented evidence of:
(select all that apply)

- ☐ Urea & Electrolytes
- ☐ GFR (without indication of renal impairment)
- ☐ Cystoscopy
- ☐ Abdominal Ultrasound
- ☐ Abdominal X-ray
- ☐ Flow Rate
- ☐ Post void residual volume
- ☐ None of the above

2.19 Is there documented evidence of the use of a pad test for routine assessment? ○ Yes ○ No

Specialised Assessment

2.20 Is there documented evidence of:

- ☐ Cystocopy for men with chronic retention, pain or recurrent urinary infection
- ☐ Flow Rate
- ☐ Post void residual volume
- ☐ None of the above

2.21 Is there documented use of routine imaging (CT / MRI / X-ray / ultrasound) for routine assessment? ○ Yes ○ No ○ Records not available on site

URODYNAMIC TESTING (CYSTOMETRY)

2.23 Did the patient have conservative treatment? ○ Yes ○ No ○ Records not available on site
If no go to 2.25 if yes go to 2.24

2.24 Is there documented evidence of the use of multi-channel cystometry **before** conservative treatment? (see help notes for guidance) ○ Yes ○ No ○ Records not available on site ○ Not documented

2.25 Did the patient have surgery or is it documented that they are considering surgery? ○ Yes ○ No ○ Records not available on site
If YES go to 2.7 / If NO go to 2.28

2.27 Is there documented evidence of multi channel cystometry for men considering surgery for their lower urinary tract symptoms (LUTS)? ○ Yes ○ No ○ Records not available on site ○ Patient not considering surgery

Diagnosis

2.28 Is there documented evidence of a clear identification of the type/cause of urinary incontinence? ○ Yes ○ No

3. MANAGEMENT

Treatment

3.1 Did the patient require treatment? ○ Yes ○ No

3.2 Did the patient have a treatment plan? ○ Yes ○ No

If you answered 'NO' to both 3.1 & 3.2 go to 3.4 otherwise answer 3.3

3.3 Which of the following methods of treatment have been used or are planned? (select all that apply)

	Used	Planned	Neither Used or Planned	
3.3i				Lifestyle modification
3.3ii				Behavioural modification
3.3iii				Bladder training regimes (supervised)
3.3iv				Containment
3.3v				Electrical stimulation (incl. afferent nerve stimulation)
3.3vi				Management of faecal impaction
3.3viii				Pelvic floor training (supervised and of minimum three months duration)
3.3ix				Review of medication
3.3x				Toileting schedules
3.3xi				Treatment of co-morbidities
3.3xii				Treatment of acute urinary tract infection
3.3xiii				Urethral milking
3.3xiv				Other (please specify)

Pharmacological interventions

3.4 Is there documented evidence of the use of anti-muscarinic medication for the treatment of Over Active Bladder (OAB)? ○ Yes ○ No ○ Did not have OAB

3.5 Is there documented evidence of a late afternoon diuretic for men with nocturnal polyuria? ○ Yes ○ No ○ Did not have nocturnal polyuria

If answer is 'Did not have…' go to 3.7

3.6 Is there documented use of DDAVP for men with nocturnal polyuria who have not benefited from other treatments? ○ Yes ○ No ○ Did not have nocturnal polyuria

3.7 Is there documented use of alpha blockers for treatment of men with moderate to severe LUTS? ○ Yes ○ No ○ Did not have moderate to severe LUTS

If answer is 'NO' or 'Did not…' Do not answer 3.9

3.8 Is there documented use of 5-AR to men with larger prostates (30ml, or PSA >1.4ng/ml) considered to be at high risk of progression? ○ Yes ○ No ○ Did not have large prostate (30ml, or PSA >1.4ng/ml)

3.9 Is there evidence of an anticholinergic being added for men with persisting storage symptoms despite treatment with alpha blockers? ○ Yes ○ No ○ Did not have storage problems

○ **Yes but**, patient did not have alpha blockers first.

Surgery

3.13 For men, did the patient consider or have surgical intervention for LUTS secondary to benign prostatic enlargement? ○ Yes ○ No ○ Records not available on site

(If YES go to 3.13i if NO go to 3.15)

3.13i Is there documented evidence of the following procedures being carried out: (select all that apply)

- ☐ Transurethral resection of the prostate (TURP)
- ☐ Holmium laser enucleation of the prostate (HOLEP) (only at specialist centre)
- ☐ Transurethral incision of the prostate (TUIP)(only in men with a small prostate)
- ☐ Open prostatectomy (OP) (only in men with a large prostate)
- ☐ Transurethral needle ablation (TUNA)
- ☐ Transurethral microwave thermotherapy (TUMT)
- ☐ High intensity focused ultrasound (HIFU)
- ☐ Transurethral ethanol ablation of the prostate (TEAP)
- ☐ Transurethral vaporization resection of the prostate (TURVP)
- ☐ None of the above

CONTAINMENT

3.15 Which of the following methods of containment have been used or are planned for treatment? (select all that apply)

- ☐ Body worn pads (disposable)
- ☐ Body worn pads (re-usable)
- ☐ All-in-one disposable
- ☐ All-in-one (re-usable)
- ☐ Reusable products (pants)
- ☐ Bed protection
- ☐ Indwelling catheter
- ☐ Intermittent catheterisation
- ☐ Devices (see help notes for guidance)
- ☐ Penile Clamps
- ☐ Containment not part of care plan
- ☐ Not documented
- ☐ Other (please specify)

3.16 Is there documented evidence of the indication for indwelling catheterisation as a form of management? ○ Yes ○ No

3.17 Is there documented evidence of the arrangement for provision of maintenance products on discharge from hospital? ○ Yes ○ No ○ Not applicable

(Hospitalised patients only)

3.17i **Is this: (choose one only)**

- ☐ Patient to buy products
- ☐ Limited supply from hospital followed by own supply
- ☐ Limited supply from hospital followed by NHS supply
- ☐ No supply from hospital with an arrangement for NHS supply

4. CARE PLAN / REVIEW / COMMUNICATION

4.1 Does the patient have a documented continence care plan? ○ Yes ○ No ***(if NO go to 4.2)***

4.1i **If yes,** when was the patient's care plan last reviewed?
- ○ Less than 6 months
- ○ 6-8 months
- ○ 9-11 months
- ○ 12 months or more
- ○ No documentation of reassessment

4.2 Is there evidence of a review for men on alpha blockers at:

4-6 weeks ○ Yes ○ No ○ Not on alpha blockers ○ Not yet relevant

Then 6-12 months ○ Yes ○ No ○ Not on alpha blockers ○ Not yet relevant

4.3 Is there evidence of a review for men on 5-AR therapy at:

3-6 months ○ Yes ○ No ○ Not on 5-AR therapy ○ Not yet relevant

Then 6-12 months ○ Yes ○ No ○ Not on 5-AR therapy ○ Not yet relevant

4.4 Is there evidence of a review for men on anti-cholinergics at:

4-6 weeks ○ Yes ○ No ○ Not on anti-cholinergics ○ Not yet relevant

Then 6-12 months ○ Yes ○ No ○ Not on anti-cholinergics ○ Not yet relevant

4.5 Where relevant is there documented evidence that a copy of the treatment plan has been given to the patient? ○ Yes ○ No ○ ***No, but*** the patient lacks mental capacity.

4.6 Where relevant, is there documented evidence that a copy of the care plan has been given to the carer/relative? ○ Yes ○ No ○ ***No, but*** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.

COMMUNICATION / INFORMATION

4.7 Is there documented evidence of a full discussion with the patient of the cause and treatment of urinary incontinence? ○ Yes ○ No ○ ***No, but*** the patient is incompetent to participate in such discussion

4.8 Where relevant, is there documented evidence of a full discussion of the cause and treatment of urinary incontinence with the carer/relative? ○ Yes ○ No ○ ***No, but*** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion.

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2010

Clinical Proforma for Bowel Problems – Faecal Incontinence

please answer ALL questions

(one proforma to be completed per patient/resident).

Your Site Code

Instructions for completion:
9. Please use a black or blue pen for all sections.
10. Please cross the boxes as appropriate (☒ or ☒).

If you are unclear of any questions on this form please use the accompanying *help booklet*.

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Tel: 020 3075 1347 / 020 3075 1619 / 020 3075 1511 or e-mail: nacc@rcplondon.ac.uk

AUDITOR DISCIPLINE

Select main discipline for this case: ○ Doctor ○ Nurse ○ Therapist ○ Manager ○ Other

DEMOGRAPHIC INFORMATION

A. Patient audit number

B. Age (years)

C. Sex ○ Male ○ Female

D. Ethnicity: ○ White British ○ Other ○ Not recorded

E. Is English the primary language of the patient? ○ Yes ○ No ○ Not known ○ Not documented

F. Please indicate in which care setting this patient is in? (choose one only)

- ☐ Care home (residential & nursing)
- ☐ Community dwelling in-patient
- ☐ In-patient of primary care trust run hospital
- ☐ Patient of local continence service
- ☐ other (please specify):

☐ Patient of acute trust hospital

1. SYMPTOMS

1.1 How often is the patient incontinent of faeces?

- ○ Every day/night
- ○ Less than once weekly
- ○ More than once weekly
- ○ Not known
- ○ Not documented

1.2 What other relevant conditions does the patient have either currently or in the past? (select all that apply)

- ☐ Anorectal surgery
- ☐ Colorectal carcinoma
- ☐ Cervical myelopathy
- ☐ Dementia
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Faecal loading or chronic constipation
- ☐ Impaired mobility
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Neurological disease
- ☐ Pelvic radiotherapy
- ☐ Pelvic surgery
- ☐ Spinal cord disease/trauma
- ☐ Stroke
- ☐ Trauma at childbirth (women only)
- ☐ Urinary incontinence
- ☐ No documentation of these
- ☐ Other (please specify) _____

1.3 Is there documented evidence that the following factors have been identified in this case? (answer all questions)

1.3i Faecal incontinence related to colorectal faecal loading — ○ Yes ○ No ○ Nothing Identified

1.3ii Faecal incontinence related to functional disability — ○ Yes ○ No ○ Nothing Identified

1.3iii Faecal incontinence due to loss of cognitive awareness — ○ Yes ○ No ○ Nothing Identified

1.3iv Faecal incontinence related to co-morbidity — ○ Yes ○ No ○ Nothing Identified

1.3v Anorectal incontinence (weak anal sphincters or anorectal condition) — ○ Yes ○ No ○ Nothing Identified

2. ASSESSMENT

History

2.1 Is there documented evidence of a bowel history? ○ Yes ○ No ***(If NO go to 2.2)***

2.1i **If yes,** does the history of faecal incontinence include:

Duration of symptoms ○ Yes ○ No ○ Not documented ○ Records not available

Daytime symptoms ○ Yes ○ No ○ Not documented ○ Records not available

Nocturnal symptoms ○ Yes ○ No ○ Not documented ○ Records not available

2.2 Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence? ○ Yes ○ No

2.3 Is the patient incontinent of urine? ○ Yes ○ No ○ Not documented ***(If NO go to 2.4)***

2.3i **If yes**, is the patient catheterised because of incontinence? ○ Yes ○ No ○ Not documented

2.4 Is the patient on medication that exacerbates faecal incontinence? ○ Yes ○ No ○ Not documented
(See help notes for types of medication) ***(If NO go to 2.5)***

2.4i Has this medication been altered to minimise its impact? ○ Yes ○ No ○ Not documented ○ Not able to minimise further

2.5 Is there evidence that the impact of symptoms on quality of life have been recorded? ○ Yes ○ No ○ **No, but** the patient is mentally incompetent to undergo an assessment.
(If NO go to 2.6)

2.5i **If yes**, has a standardised assessment scale been used e.g. Faecal Incontinence Quality of Life Scale? ○ Yes ○ No ○ Not documented

Cognitive status

2.6 Has the patient's cognition been assessed? ○ Yes ○ No ○ Not documented
(see help notes for guidance) ***(If YES answer ALL / If NO or Not documented answer 2.6i and proceed to 2.7)***

2.6i Is the patient's cognitive status: ○ Unimpaired ○ Mild ○ Moderate ○ Severe ○ Insufficient information to calculate
(see help notes for guidance)

2.6ii Is there documented use of a formal scoring system for assessment of cognition? ○ Yes ○ No
(see help notes for guidance)

Functional status

2.7 Has the patient's functional ability been assessed? ○ Yes ○ No ○ Not documented
(see help notes for guidance) ***(If YES answer all / If NO or Not documented answer 2.7i and proceed to 2.8)***

2.7i Is the patient's functional status: ○ Unimpaired ○ Mild ○ Moderate ○ Severe ○ Insufficient information to calculate
(see help notes for guidance)

2.7ii Is there documented use of a formal scoring system for assessment? ○ Yes ○ No
(see help notes for guidance)

EXAMINATION

Basic examination

(for guidance on what constitutes "basic examination" see help notes)

2.8 Is there documented evidence of rectal examination to exclude faecal loading? ○ Yes ○ No ○ **No, but** the patient has a colostomy or some other form of faecal diversion.

Focused examination

(for guidance on what constitutes "focused examination" see help notes)

2.9 Is there documented evidence that a focused examination has been performed? ○ Yes ○ No ***(If NO go to 2.10)***

2.9i **If yes**, who has performed the examination? Choose one only:

- ○ Geriatrician
- ○ Gynaecologist (women only)
- ○ GP
- ○ Nurse
- ○ Other (please specify) _____
- ○ Therapist
- ○ Urologist
- ○ Hospital ward based doctor
- ○ Gastroenterologist

2.9ii **If yes**, is there documented evidence of the following (answer all questions)

2.9ii a Assessment of mobility ○ Yes ○ No ○ Not required

2.9ii b Examination of the abdomen for palpable mass or bladder retention ○ Yes ○ No ○ Not required

2.9ii c Examination of perineum and anus. ○ Yes ○ No ○ Not required

2.9ii d	Rectal examination	○ Yes ○ No ○ Not required
2.9ii e	Bowel imaging	○ Yes ○ No ○ Not required
2.9ii f	Neurological examination, if neurological symptoms suspected	○ Yes ○ No ○ Not required

Diagnosis

2.10 For which tests is there documented evidence to aid diagnosis?

2.10i	Stool culture	○ Yes	○ No	○ **No, but** specialist records unavailable for audit	○ Not required
2.10ii	Abdominal x-ray	○ Yes	○ No	○ **No, but** specialist records unavailable for audit	○ Not required
2.10iii	Colonoscopy	○ Yes	○ No	○ **No, but** specialist records unavailable for audit	○ Not required
2.10iv	Other (please specify)				

2.11 Is there documented evidence of a clear identification of the types or causes of bowel problem? ○ Yes ○ No ○ **No, but** specialist records unavailable for audit (relevant to care homes)

---

3. MANAGEMENT

Treatment

3.1 Is there documented evidence that **condition-specific intervention** has been given or planned for the following: (see help notes for guidance)

3.1i	Faecal loading?	○ Yes	○ No	○ Not applicable
3.1ii	Potentially treatable causes of diarrhoea?	○ Yes	○ No	○ Not applicable
3.1iii	Rectal prolapse or third-degree haemorrhoids?	○ Yes	○ No	○ Not applicable
3.1iv	Acute anal sphincter injury?	○ Yes	○ No	○ Not applicable
3.1v	Acute disc prolapse/cauda equina syndrome?	○ Yes	○ No	○ Not applicable
3.2	Are the patient's goals for treatment recorded?	○ Yes	○ No	○ **No, but** the patient is incompetent to partake in decision making.
3.3	Did the patient require treatment?	○ Yes	○ No	
3.4	Did the patient have a treatment plan?	○ Yes	○ No	

If you answered 'NO' to both 3.3 & 3.4 go to 3.6 otherwise answer 3.5

3.5 Which of the following methods of treatment have been used or planned? (select all that apply)

	Used	Planned	Neither used or planned	
3.5i	○	○	○	Advice on general health
3.5ii	○	○	○	Advice on lifestyle
3.5iii	○	○	○	Antidiarrhoeal drugs
3.5iv	○	○	○	Biofeedback
3.5v	○	○	○	Bowel clearance programme
3.5vi	○	○	○	Bowel retraining
3.5vii	○	○	○	Dietician
3.5viii	○	○	○	Faecal incontinence chart
3.5ix	○	○	○	Implementation of bowel training regimes / techniques
3.5x	○	○	○	Improved mobility
3.5xi	○	○	○	Improved quality of, and access to, toilet facilities
3.5xii	○	○	○	Pelvic floor training
3.5xiii	○	○	○	Laxatives / enemas/ suppositories
3.5xiv	○	○	○	Management of behavioural problems in severe dementia
3.5xv	○	○	○	Review of medication
3.5xvi	○	○	○	Rectal irrigation
3.5xvii	○	○	○	Specific pharmacological interventions, e.g: metronidazole for *C. difficile*

3.5xviii	○	○	○	Colostomy or ileostomy
3.5xix	○	○	○	Surgery
3.5xx	○	○	○	Toileting advice
3.5xxi	○	○	○	Toileting schedules
3.5xxii	○	○	○	Treatment of co-morbidities
3.5xxv	○	○	○	Other (please specify)

3.6 Is there documented history of referral to other providers of treatment? (select all that apply)

- ☐ Colorectal surgeon
- ☐ Bowel dysfunction practitioner
- ☐ Continence practitioner (see help notes for guidance)
- ☐ Dietitian
- ☐ Gastroenterologist
- ☐ General practitioner (GP)
- ☐ Geriatrician
- ☐ Neurologist
- ☐ Practice nurse
- ☐ Unable to retrieve data, records not available on site(Care Homes Only)
- ☐ Not documented
- ☐ Other (please specify)
- ☐ None of the above

3.7 Is there documented evidence that long-term management of Faecal Incontinence has been given or planned? (answer all questions)

3.7i	Advice and information on continence products	○ Yes	○ No	○ Not required
3.7ii	Advice on skin care	○ Yes	○ No	○ Not required
3.7iii	Advice relating to preservation of dignity	○ Yes	○ No	○ Not required
3.7iv	Advice relating to preservation of independence	○ Yes	○ No	○ Not required
3.7v	Contact details for relevant support groups	○ Yes	○ No	○ Not required
3.7vi	Periodic review of symptoms	○ Yes	○ No	○ Not required
3.7vii	Psychological and emotional support	○ Yes	○ No	○ Not required

Containment

3.8 Which of the following methods of management have been used or are planned for treatment? (select all that apply)

- ○ Adapted clothing
- ○ Advice on skin care and odour control
- ○ Anal plugs
- ○ Bags
- ○ Devices to aid toileting (see help notes)
- ○ Pads
- ○ Not documented
- ○ Other (please specify)
- ○ None of the above

4. CARE PLAN / COMMUNICATION

4.1 Does the patient have a documented continence care plan? (see help notes for guidance) ○ Yes ○ No **(if NO go to 4.2)**

4.1i **If yes,** when was the patient's care plan last reassessed?

- ○ Less than 6 months
- ○ 6-8 months
- ○ 9-11 months
- ○ 12 months or more
- ○ No documentation of reassessment

4.2 Is there documented evidence that a copy of the care plan has been given to the patient? ○ Yes ○ No ○ **No, but** the patient is mentally incompetent

4.3 Is there documented evidence that a copy of the care plan has been given to the carer/relative? ○ Yes ○ No ○ **No, but** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion

Communication / Information

4.4 Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem? ○ Yes ○ No ○ **No, but** the patient is mentally incompetent to participate in such discussion

4.5 Is there documented evidence of a full discussion of the causes and treatments of the bowel problem with the carer/relative? ○ Yes ○ No ○ **No, but** the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion

APPENDIX 6: Clinical Audit Participating Sites – Acute

Aintree University Hospitals NHS Foundation Trust
Airedale NHS Trust
Barking Havering and Redbridge NHS Trust
Barnet & Chase Farm Hospitals NHS trust
Barnsley Hospital NHS Foundation Trust
Barts and The London NHS Trust
Basildon & Thurrock University Hospitals Foundation Trust
Bedford Hospital NHS Trust
Blackpool Fylde & Wyre NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Brighton & Sussex University Hospitals NHS Trust - Princess Royal Hospital
Brighton & Sussex University Hospitals NHS Trust - Royal Sussex Hospital
Buckinghamshire Hospitals NHS Trust
Burton Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Trust
Cambridge University Hospitals Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
Chesterfield Royal Hospital
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
County Durham & Darlington NHS Foundation Trust - Darlington Memorial Hospital
County Durham & Darlington NHS Foundation Trust - University Hospital of North Durham
Derby Hospitals NHS Foundation Trust
Doncaster & Bassetlaw Hospital NHS Foundation Trust
Dorset County Hospital NHS Foundation Trust
Dudley Group of Hospitals Foundation Trust
Ealing Hospital NHS Trust
East Cheshire NHS Trust
East Lancashire Hospitals Trust - Royal Blackburn Hospital
East Sussex Hospitals NHS Trust - Conquest Hospital
East Sussex Hospitals NHS Trust - Eastbourne District General
Epsom & St Helier University Hospitals NHS Trust
Gateshead Health NHS Foundation Trust
George Eliot Hospital NHS Trust
Guy's & St. Thomas' NHS Foundation Trust
Harrogate & District NHS Foundation Trust
Heart of England NHS Foundation Trust
Heatherwood & Wexham Park Hospitals NHS Foundation Trust
Hereford Hospitals NHS Trust
Hillingdon Hospital NHS Trust
Homerton University Hospital NHS Foundation Trust
Hull & East Yorkshire Hospitals NHS Trust
Imperial College Healthcare NHS Trust
Kettering General Hospital
Kings College Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Leeds Teaching Hospitals NHS Trust
Luton & Dunstable Hospital NHS Foundation Trust
Maidstone & Tunbridge Wells NHS Trust
Mayday Healthcare NHS Trust
Medway NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust

Mid Essex Hospitals Services NHS Trust - (St John's Hospital)
Mid Staffordshire NHS Foundation Trust
Mid Yorkshire Hospital NHS Trust
Milton Keynes Hospital NHS Foundation Trust
Newham University Hospital NHS Trust
North Bristol NHS Trust
North Middlesex Hospital
North Tees & Hartlepool NHS Trust - University Hospital of Hartlepool
North Tees & Hartlepool NHS Trust - University Hospital of North Tees
Northern Devon Healthcare NHS Trust
Northern Lincolnshire & Goole Hospitals NHS Trust - Diana, Princess of Wales Hospital
Northern Lincolnshire & Goole Hospitals NHS Trust - Scunthorpe & Goole Hospitals
Northumbria Healthcare NHS Foundation Trust - Hexham General Hospital
Oxford Radcliffe Hospitals NHS Trust
Peterborough & Stamford Hospitals NHS Foundation Trust
Plymouth Hospitals NHS Trust - Derriford Hospital
Poole Hospital NHS Foundation Trust
Queen Victoria Hospital NHS Foundation Trust
Royal Berkshire NHS Foundation Trust
Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon & Exeter NHS Foundation Trust
Royal Free Hampstead NHS Trust (Royal Free Hospital)
Royal Surrey County Hospital NHS Trust
Royal United Hospital Bath NHS Trust
Royal Wolverhampton NHS Trust
Salford Royal NHS Foundation Trust
Salisbury Foundation NHS Trust
Sandwell &West Birmingham NHS Trust - City Site
Sandwell &West Birmingham NHS Trust - Sandwell Site
Sarborough & North East Yorkshire Healthcare NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Sherwood Forest Hospitals
Shrewsbury & Telford Hospitals NHS Trust - Princess Royal Hospital
Shrewsbury & Telford Hospitals NHS Trust - Royal Shrewsbury Hospital
South Devon Healthcare NHS Foundation Trust
South Downs Health NHS Trust
South London Healthcare Trust - Queen Elizabeth Hospital
South London Healthcare Trust - Queen Mary's Sidcup
South Tees Hospitals NHS Trust
South Tyneside Foundation Trust
Southampton University Hospitals NHS Trust
Southport and Ormskirk Hospitals NHS Trust
St George's Healthcare NHS Trust
St Helens and Knowsley Teaching Hospital
Stockport NHS Foundation Trust
Surrey & Sussex Healthcare NHS Trust
Tameside Hospital NHS Foundation Trust
Tauton & Somerset Foundation NHS Trust
The Great Western Hospitals NHS Foundation Trust
The Ipswich Hospital NHS Trust
The Lewisham Hospital NHS Trust
The Newcastle upon Tyne Hospitals NHS Foundation Trust
The North West London Hospitals NHS Trust - (Central Middlesex Site)

The Queen Elizabeth Hospital King's Lynn NHS Trust
The Rotherham NHS Foundation Trust
The Royal Liverpool & Broadgreen University Hospital NHS Trust
Trafford Healthcare NHS Trust
United Lincolnshire Hospitals Trust - Lincoln County Hospital
United Lincolnshire Hospitals Trust - Pilgrim Hospital
University Hospital Bristol NHS Foundation Trust
University Hospital Coventry & Warwickshire NHS Trust
University Hospital of North Staffordshire NHS Trust
University Hospital of South Manchester NHS Foundation Trust
University Hospitals Birmingham NHS Foundation Trust
University Hospitals of Leicester NHS Trust
University Hospitals of Morecambe Bay NHS Trust
Walsall NHS Trust
Warrington and Halton Hospitals NHS Foundation
West Hertfordshire Hospitals NHS Trust
West Middlesex University Hospitals NHS Trust
Western Sussex Hospitals NHS Trust - St Richards Hospital
Whipps Cross University Hospital NHS Trust
Wirral University Teaching Hospital NHS Foundation Trust
Worcestershire Acute Hospitals NHS Trust
Wrightington, Wigan & Leigh NHS Foundation Trust
Yeovil District Hospitals NHS Foundation Trust
York Hospitals NHS Foundation Trust
Northumbria Healthcare NHS Foundation Trust - North Tyneside General
Northumbria Healthcare NHS Foundation Trust - Wansbeck General Hospital
Nottingham University Hospitals NHS Trust - City Hospital & Queens Medical Centre
The North West London Hospitals NHS Trust - (Northwick Park & St Marks Site)
Pennine Acute Hospitals NHS Trust - North Manchester General Hospital
Pennine Acute Hospitals NHS Trust - Rochdale Infirmary
Pennine Acute Hospitals NHS Trust - Fairfield General Hospital
Pennine Acute Hospitals NHS Trust - The Royal Oldham Hospital
Western Sussex NHS Trust - Worthing & Southlands Site
Frimley Park Hospital NHS Foundation Trust
Royal Bolton Hospital NHS Foundation Trust

Clinical Audit Participating Sites – Mental Health Trust

Bradford District Care Trust
Cambridgeshire and Peterborough NHS Foundation Trust
Camden & Islington NHS Foundation Trust
Cornwall Partnership NHS Trust
Coventry & Warwickshire NHS Partnership Trust
Cumbria Partnership NHS Foundation Trust
Hampshire Partnership NHS Foundation Trust
Hertfordshire Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust - Site 1
Leicestershire Partnership NHS Trust - Site 2
Lincolnshire Partnership NHS Foundation Trust
Manchester Mental Health & Social Care Trust
Norfolk and Waveney Mental Health NHS Foundation Trust
North East London NHS Foundation Trust
Northamptonshire Healthcare NHS Foundation Trust
Oxleas NHS Foundation Trust
Pennine Care NHS Foundation Trust

Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust
Sandwell Mental Health and Social Care NHS Foundation Trust
Somerset Partnership NHS Foundation Trust
South Essex Partnership University NHS Foundation Trust
South London & Maudsley NHS Foundation Trust
South Staffordshire & Shropshire Healthcare NHS Foundation - Shropshire
South Staffordshire & Shropshire Healthcare NHS Foundation - South Staffs
Surrey and Borders Partnership NHS Foundation Trust
Tees Esk & Wear Valleys NHS Foundation Trust

Clinical Audit Participating Sites – Primary Care

Ashton, Leigh & Wigan NHS Trust
Bassetlaw Primary Care Trust
Belfast Health & Social Care Trust - Belfast City Hospital
Belfast Health & Social Care Trust - North & West Belfast Community Service
Belfast Health & Social Care Trust - South & East Belfast Community Service
Birmingham East & North Primary Care Trust
Bournemouth & Poole Community Health Services
Bromley Primary Care Trust
Cambridgeshire Primary Care Trust (Community Services)
Camden Primary Care Trust Provider Services
Central & Eastern Cheshire Primary Care Trust - Cheshire East Community Health
Devon Primary Care Trust
Dorset Primary Care Trust
East Lancashire Primary Care Trust
East Riding of Yorkshire Primary Care Trust
NHS South of Tyne & Wear - Gateshead Primary Care Trust
Hounslow Community Healthcare
Isle of Wight NHS Primary Care Trust
Knowsley Primary Care Trust
Lambeth Primary Care Trust
Lewisham Primary Care Trust
Newcastle Primary care Trust
NHS Barnsley
NHS Bedfordshire
NHS Berkshire West
NHS Blackburn with Darwen
NHS Brent (Brent Community Services)
NHS Calderdale
NHS Cornwall & Isles of Scilly Community Health Services
NHS Darlington
NHS Eastern & Coastal Kent Community Services
NHS Gloucestershire
NHS Greenwich (Greenwich Community Health Services)
NHS Hartlepool
NHS Lincolnshire (Community Health Service/Teaching)
NHS Mid Essex
NHS North East Essex
NHS North Lincolnshire (Community Services)
NHS North of Tyne - North Tyneside Primary Care Trust
NHS Nottingham City
Outer North East London Community Service (Redbridge)

NHS South of Tyne & Wear - South Tyneside Primary Care Trust
NHS South West Essex Community Services (Provider)
NHS Surrey
NHS Telford and Wrekin
NHS Warrington - Community Services Unit
NHS Warwickshire
NHS Western Cheshire - Community Care
NHS Western Cheshire - Ellesmere Port Hospital
NHS Wiltshire
NHS Wirral
North East Lincolnshire Care Trust Plus
Oldham Primary Care Trust (Oldham Community Health Services)
Outer North East London Community Service (Havering)
Oxfordshire Primary Care Trust
Peterborough Community Services
Plymouth Teaching Primary Care Trust
Sandwell Primary Care Trust
Sheffield Primary Care Trust
Solihull NHS Care Trust
Somerset Primary Care Trust (Community Health)
South Birmingham Primary Care Trust
South Staffordshire Primary Care Trust
Southampton City Primary Care Trust
NHS Southwark
Stockport Primary Care Trust (NHS Stockport)
NHS South of Tyne & Wear - Sunderland Teaching Primary Care Trust
Sutton & Merton Primary Care Trust
Swindon Primary Care Trust
Tower Hamlets Community Health
Wakefield District Community Healthcare Services for NHS Wakefield District
Western Health & Social Care Trust
Worcestershire Primary Care Trust
NHS Stockton-on-Tees
NHS Middlesbrough
Liverpool Primary Care Trust - Provider Services
NHS Enfield
South East Essex Primary Care Trust
NHS Cornwall & Isles of Scilly Community Health Services - Cambourne/Redruth Community Hospital
NHS Eastern & Coastal Kent Community Hospital
NHS Cornwall & Isles of Scilly Community Health Services - Falmouth Community Hospital
Plymouth Teaching Primary Care Trust - Site 2
NHS Nottinghamshire County - Mansfield Community Hospital
Outer North East London Community Service (Waltham Forest)
NHS North of Tyne - Northumberland Care Trust
Heart of Birmingham Primary Care Trust
NHS West Hertfordshire
Tameside & Glossop Primary Care Trust
Central London Community Healthcare

Clinical Audit Non Participating Sites – Acute

Ashford & St Peter's Hospitals NHS Trust
Basingstoke & North Hampshire NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Northern Health and Social Care Trust
Papworth Hospital NHS Foundation Trust
The Whittington Hospital NHS Trust
West Suffolk Hospital NHS Trust
Winchester & Eastleigh Healthcare NHS Trust

Clinical Audit Non Participating Sites – Mental Health Trust

Derbyshire Mental Health Services NHS Trust
Devon Partnership NHS Trust
Dorset Healthcare NHS Foundation Trust
East London NHS Foundation Trust
Kent & Medway NHS & Social Care Partnership Trust
Lancashire Care NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust

Clinical Audit Non Participating Sites – Primary Care

Bradford & Airedale Teaching Primary Care Trust
Harrow Primary Care Trust
Leicestershire County and Rutland Community Health Services
Medway Primary Care Trust
Milton Keynes Community Health Services
NHS Bolton
NHS Central Lancashire
NHS City & Hackney (Community Services)
NHS Kirklees
NHS Luton - Luton Community Services
NHS Manchester
NHS Newham
NHS West Essex
North Lancashire Teaching Primary Care Trust
North Yorkshire & York Primary Care Trust
Salford Primary Care Trust
West Kent Primary Care Trust