Royal College of Physicians

Setting higher standards

National audit of continence care (NACC)

Pilot audit evaluation report

June 2012

Commissioned by:

HQIP
Healthcare Quality Improvement Partnership

Contents

List of tables

Report authors

Report prepared by

Dr Danielle Harari MB FRCP
Associate director, national audit of continence care
Clinical Effectiveness and Evaluation Unit, Royal College of Physicians
Consultant physician, senior lecturer

Mrs Janet Husk, RGN, MSc, Dip
Project manager, national falls and bone health audit,
Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

Mr Derek Lowe, MSc, C.Stat
Medical statistician
Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

Jose Lourtie BSc, MA
Project coordinator
Clinical Effectiveness and Evaluation Unit, Royal College of Physicians

Report approved by the National Audit of Continence Care steering group. (Appendix 1)

Acknowledgement
We would like to thank all the NHS trusts and care homes who volunteered to participate in this pilot audit and for all their hard work.
We are also grateful for the Guys & St Thomas' Hospital continence patient group for its help and feedback.
Finally we would like to thank everyone who assisted in the design, performance and analysis of this project.

Foreword

The National Audit of Continence Care (NACC) is run by the Clinical Effectiveness and Evaluation Department of the Royal College of Physicians and commissioned by the Healthcare Quality Improvement Partnership (HQIP).

The first report was published in 2005 and subsequent audits took place in 2006 and 2010. These audits have regularly showed that there is a real need for improvements in continence care for people with bladder and bowel problems, particularly in those aged 65+.

The most recent report, published in September 2010, describes in detail the care given to almost 19,000 adults with continence problems in a variety of NHS settings such as hospital wards, hospital outpatient clinics, mental health hospitals, GP surgeries and care homes. The audit results showed that there had been some improvements in care but there was still much that could be done.
The 2010 audit was evaluated by seeking feedback from audit participants at workshops and through an online survey, and considered this alongside audit results before making four key changes:

1. The data set was shortened to make it more user-friendly and educational, without compromising the auditing of the core standards for bladder and bowel continence care.

2. Content was focussed on areas of most concern in terms of poor performance as identified in the audit i.e. lack of proper assessment, under-treatment (especially in patients aged 65+), and poor communications with patients.

3. A new technology for national audit was developed and tested. It provides instant feedback of results, so that professionals can rapidly act on findings and re-measure the effect of their actions as often as they need do so, thus promoting audit cycles and continuous quality improvement. Practice can be compared between more than one site within an organisation, for example more than one hospital ward or hospital.

4. Care home participants requested a specific audit tool for that setting, addressing both the technical difficulties, and the particular needs of residents (in whom incontinence rates can be very high).

A two month pilot was carried out to test the four changes. This report evaluates these changes and their applicability to the future national audit of continence care (NACC). This is the report on the audit questions and results, the web tool format and feedback received from participating sites with conclusions for the future audit plans, based on this evaluation.

In conjunction with this pilot a patient experience questionnaire was developed and tested by continence user groups and professionals as an important new patient-centred component to the National Audit of Continence Care. This report will refer to some of this patient involvement work in this current report, although a separate full report of the patient experience pilot will also be made available to HQIP, Department of Health, stakeholders, and participating sites.

Executive summary

Introduction

The National Audit of Continence Care (NACC) is the only national audit that examines and promotes quality of continence care in adults aged 18+ across all healthcare settings. This new pilot audit incorporated feedback from previous NACC participants, that it should be shorter and easier to use, focus on poor performance areas, and include national drivers in continence care (e.g. catheter use, pad provision, NICE-based care, staffing, training and resource use). The pilot also tested new audit technology that DH had developed through working with the clinical effectiveness committee at the British Geriatrics Society. The NACC team further refined this technology resulting in the revised audit - an easily accessible web tool, with continuous data entry and instant reporting of results. The system allowed participants to enter data over cycle periods of their choice, and to compare results at more then one site in their organisation (e.g. wards, care homes, GP practices). Eighty-three organisations submitted data in the pilot (60 acute hospitals, 23 primary care trusts) on 814 cases.

How well did the new audit work?

- The short and concise audit forms were well-received, with feedback that the clinical audit tools could also be used for continence training and case-based discussions
- A number of questions in the organisational audit scored >95% - for instance all primary care sites reported having written policies, care pathways and training programme. This indicates that in the next version, these questions need to be more specific with subsections and requests for supporting documentation (e.g. written policy) to be sent electronically
- A large number of sites reported that they did monitor patient experience, and again this question will need to be developed to scrutinise exactly how sites are doing this
- 60% found collecting patient data for the pilot audit easy - difficulties were mostly due to problems with lack of information in the notes being audited, rather the pilot tool itself. Good feedback was received on a new question that allowed sites to describe specifically what notes had been audited (e.g. in primary care, GP notes versus community continence nurse notes)
- Only 3 sites reported any problems entering data on the web tool
- Sites liked the option of performing repeat audits themselves including choosing the time periods between cycles according to their needs
- 95% of respondents found the instant report function easy to use, and 90% found the information provided useful. There is scope to improve on this function in terms of how results are presented

Results

Within the limitations of this being a pilot audit, the results meaningfully profiled both organisational and evidence-based continence care, demonstrating that there a still gaps in services and clinical care.

- **Written polices** for continence management were non existent in almost half of the acute NHS sites
- **Quality indicators** (e.g. Commissioning for Quality and Innovation - CQUIN) for catheter-acquired Urinary tract infection (UTI) were present in two-thirds of all sites, but those for urinary and faecal incontinence were far less evident.
- **Number of FTE continence nurse specialists** had fallen in the previous 12 months in 27% of primary care sites and 18% of acute sites, while the clinical audit showed that continence nurse specialists are delivering the majority of continence care. This links in with the lack of GP involvement shown in the clinical part of the audit, where none of the continence assessments in primary care were done by GPs.
- **Structured programmes for staff training** were non existent in 54% of acute Trusts. Although staff training was present in all primary care sites, these largely served nursing staff, with only a quarter of programmes targeting doctors.

- **User groups** A minority of continence services had dedicated user groups (31% primary care, 19% acute), but the comments we received showed that continence services are working with users in various other ways (e.g. via Multiple Sclerosis or dementia groups).
- **Screening question** was used by the majority of sites in their routine clinical practice - 40% of acute sites however did not have an existing continence care pathway to be initiated when a patient answers yes to the screening question.
- **Assessment focusing on finding the cause of urinary incontinence** was not done in 24% of cases in primary care, and 49% in acute care. One quarter of acute care patients did not have any urinary symptoms recorded. A low proportion of men had a digital rectal examination to examine prostate size (13% in primary care, 29% in acute care).
- **Assessment focusing on finding cause of faecal incontinence** was undertaken in 84% of cases in primary care (none by GPs), and 58% in acute care. One quarter of acute care patients did not have any faecal incontinence (FI) symptoms recorded. 84% of primary and 62% of acute care cases had a treatment plan recorded in the notes.
- **Catheterisation rate** in the community was 6%, consistent with national benchmark. Twenty-one percent of acute cases were catheterised but on further questioning in the pilot, 90% had an appropriate reason for insertion documented.
- **Impact of incontinence on quality of life** was assessed in 69% of primary care and 25% of acute care patients, similar proportions to those in whom patient own goals had been documented. Impact of faecal incontinence on quality of life was assessed in 69% of primary care and 20% of acute care patients.

Using this audit to improve continence care

- A new question focussed on whether patients were identified for the audit through routine screening, referrals or only by virtue of undertaking the audit. The results highlighted the need for improved screening in routine practice as there were a number in the latter category (i.e. missed or undiagnosed cases). There was also a discrepancy with the high percentage of responses in the organisational audit stating that screening is done as part of routine care.
- The questions profiling continence services (e.g. number of continence nurse specialists, training details) can inform service requirements and resource allocation
- The audit successfully measured variability across sites
- Areas of suboptimal clinical practice were effectively highlighted
- Participants appreciated the new questions measuring data required for national CQUINs and quality indicators (e.g. catheter use, urinary tract infection), and saw potential in this audit being used within routine practice
- 85% of sites said that they could use this tool to continuously quality assess their service
- 66% said they could use the audit information to action change
- 76% saw value in the audit as an educational tool, especially within their own teams.

Auditing continence in social care and care homes

Another new aspect in this pilot was the development and pilot of an audit tool specifically designed for use in care homes. 26 care homes registered to participate, but 15 did not complete the pilot, reasons being lack of staff time, staff changes and difficulties rather than any problems with the audit itself. This provided a snapshot of the difficulties in completing audits in care homes. Participating care homes did however feed back favourably on use of this tool on a regular basis to audit care, improve quality and prompt care planning.

Using this pilot to inform future plans for the national continence care audit

Sites participating in this pilot reported that, apart from local catheter care audits, the National Audit of Continence Care audit has been primarily used to audit bladder and bowel care in their organisations emphasising the need to establish funding for an ongoing programme. NACC has shown that

considerable gaps in continence care service and delivery exist across NHS health and social care settings. We feel that this pilot has informed future plans for a national continence care audit as follows:

National continence care audit web tool

- **'Local' audit for continuous quality improvement** Pilot participants confirmed that 'local 'audit embedded within a national audit framework is most powerful in practice change implementation. The national audit could build on this continuous audit technology that allows sites to enter data at any time in to the web tool, perform a 'local' audit, look at their results, identify action required, implement and then re-audit to see if their actions have improved care.
- **Annual national audit for public report and benchmarking** The piloted technology also allowed for an annual national audit to be conducted between predefined dates as per previous continence care audits. This could provide fully analysed data, local site reports, and a public national report with benchmarking data
- **Key variables as quality markers** Key variables were selected during the pilot via expert consensus (NACC steering group) and these were then effectively provided to sites within the instant results reporting facility. Identifying key markers of quality organisational and clinical care would however require further refinement
- **Benchmarking facility** The national benchmarking facility relating to the annual national audit would need development to provide sites with quality markers refined as above and categorisation into upper, middle, lower quartile levels of good care
- **Linking quality care to organisational profile** The pilot usefully linked organisational data such as staffing levels and training needs with clinical data. The national audit could do this in more sophisticated ways by for instance looking at associations between low levels of continence nurse advisors or insubstantial training programmes with quality of care. Organisations could take such analysis into consideration when commissioning continence services.
- **Comparing standards in younger and older people** The national audit should continue to profile continence care in all adult (18+) age groups, which effectively brings together a wide number of provider disciplines (surgeons, nurses, geriatricians etc.) thus promoting integrated care. The audit should also provide comparative reports for those age 65+ years versus those <65 as per the 2010 NACC. In 'local' audit, organisations may use the new web tool function of comparing sites to compare different patient groups relevant to their practice.
- **Shared learning and peer support** The national audit should facilitate sites in improving continence care by providing [a] providing benchmarked quality markers of that high and low performing sites can be identified [b] a forum for sharing best practice e.g. policies, assessment tools, action plans, business plans [c] opportunities for peer support. Further work would be needed to look at how best to do this.
- **Case identification, coding, and screening** A new question focussed on whether patients were identified for the audit through routine screening, referrals or only by virtue of undertaking the audit. The results highlighted the need for improved screening in routine practice as there were a number in the latter category (i.e. missed or undiagnosed cases) The next national audit could develop this section further to promote screening and better coding for incontinence.

Patient experience

- **Patient experience subsection** A large number of sites reported that they did monitor patient experience but there was discrepancy between this organisational view, and the number of cases who had quality of life assessed. This audit subsection would need further development to scrutinise exactly how sites are looking at patient experience, and how relevant this is to the specific experience of continence care. The pilot highlighted that user support can be available through chronic disease support groups (e.g. Multiple Sclerosis, Parkinson's disease) and this audit subsection should reflect that.
- **Patient experience questionnaire – national implementation** The patient experience questionnaire pilot that we ran alongside the pilot audit detailed people's experience of continence services, as well as collecting free text comments, many of which are quoted in this

report. This patient report should compliment the national audit and would be very important to pursue. This would require defining the method of delivery (could also be online), how patients are identified, and what feedback would be given to participants and to relevant continence services. Linking patient experience to quality markers through audit would be innovative and informative.

- **Privacy and Dignity subsection** This should evolve to include all national indicators plus those considered to be important by users as ascertained from the NACC Privacy and Dignity project in older people with incontinence. This subsection could also include linked audit indicators such as good nutrition, pressure area care, care for people with dementia as per current NHS concerns in the NHS regarding care of vulnerable and older people (e.g. recent Patient Association report 'We've been listening, have you been learning report. Nov 2011').
- **Audit report for users 'What to expect from your NHS Continence Care services'** The 2010 audit report was rewritten with continence users as a well-received (and much down-loaded) user friendly report that included detail on what patients with incontinence should expect from a quality service. The national audit should similarly generate an annual user friendly report. There would be further work to do to involve a wider set of users (e.g. patients with MS) and carers, and to expand distribution.

Care homes continence care audit tool

The pilot showed that the audit tool is acceptable to care homes, but also highlighted difficulties (mainly in relation to staffing levels and changes) that care homes face in adhering to national audit. Refining use of audit in care homes in relation to continence care, privacy and dignity, patient experience is important as so many care home residents suffer from incontinence

- **Refining audit questions** Wider consultation with providers and users in care homes could be set up to refine the audit questions and include more indicators on related quality care and patient safety.
- **Include nationally required performance indicators** To improve adherence, the audit should include key performance indicators and CQC requirements related to continence
- **Instant results reporting** This was not tested in care homes but it should be made similarly available in this setting, having established as above what the key indicators and quality markers are. The content and delivery of the report should be established through the wider consultation group as above.
- **Using audit as educational and clinical tool** Care homes in the pilot felt the audit tool was clear enough to be used as a NICE-adherent learning tool. This approach could be formalised as it would both improve audit engagement and promote better standards of care.
- **Access to all care homes** The pilot showed that even those care homes willing to engage with audit had difficulty in participating and reporting. Barriers to implementation would need to be identified and tackled, with the eventual aim of providing the audit tool to all major care home providers.

Recommendations

The pilot audit results, from the acute, community and mental health participants, illustrate that there is still variation in the provision of continence care. Therefore there is a need for a national audit of continence care in some form. The technology used for the pilot would require further work to ensure it meets local and national requirements and this should be undertaken.
The care home tool needs further refinement to again ensure it meets care home and national requirements. Consultation should be considered.

The patient questionnaire would need further work but there is a possibility it could be used to triangulate against results from a clinical or organisational audit as it is structured around data items in the pilot audit and from a small group of service users. Patient or public involvement should be considered in future work.

Background and learning from 2010 NACC

The new audit tool built on findings from the National Audit of Continence Care 2010. The 2010 audit surveyed care given to 18,253 people across 135 NHS Acute Trusts, 26 Mental Healthcare Trusts, 86 Primary Care Trusts, and 122 care homes. The areas of poor performance as summarised below were all examined in the new audit tool.

Continence services were poorly organised 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.

Training of health care professionals was inadequate Provision of training for health care workers to manage bladder and bowel problems was patchy across the nation, and overall occurred in less than 50% of acute hospitals.

Clinical services were not adhering to national guidance for good practice
These gaps in organisational standards for continence care lead to gaps in clinical care. NACC showed that overall adherence to the national guidance (NICE) for urinary and faecal incontinence was very variable.

Patients were not getting the care they deserve
Evidence suggests that healthcare professionals were not consistently

- asking about incontinence in people who are at risk of the condition (e.g. older people) - *people are often too embarrassed to mention the symptom themselves and should be asked*
- providing assessment, diagnosis and follow-through according to standard practice - *even where a person is found to have incontinence, diagnosis of causes and therefore curative treatment is often not provided*
- communicating information about causes and treatments of patients' incontinence - *it is so important to talk to patients about this so that they can have the confidence to deal with it*
- asking patients about their *own* goals for treatment
- assessing the impact of incontinence on quality of life - *the effect on people's lives can be devastating and people should be asked about this*
- making care plans to achieve treatment goals and sharing these with patients and (where relevant) carers - *a lack of organised treatment planning results in a lack of effective treatment*

Older people received particularly poor care, even though they suffer more from incontinence Overall, quality of care appeared worse for older people (patients aged 65 years and over as compared with those aged <65) even though older people suffer more from incontinence. This is unequal provision of health care. There remained much room to involve older patients in their own care of what is often a distressing, yet curable condition.

We also revised the new audit to incorporate the following feedback from 2010 audit participants
Audit tool – Some of the questions were too ambiguous and sites found them difficult to understand or answer. It was not always clear what the question was trying to get at. This led to a great deal of 'Free Text' being added as sites could not find an option that would fit the answer they wanted to give. A large amount of free text makes data cleaning more complicated and makes it more difficult for accurate conclusions to be drawn from the audit. The audit was seen as too long and put many people off even before they started collecting data. *The new audit is shorter, more concise and with simpler, clearer questions* **(see appendix 2).**

Help Notes – Needed to be more thorough with greater explanation of what is required to be answered. Lack of information led to (as above) a great deal of free text being added in the 'other' boxes which

leads to problems when analysing the data. Also needed to be simpler to understand and use language that does not assume a high level of expertise. *The new helpnotes are more detailed and provide explanations as to why NACC is asking this question (including evidence-base) as well as information how to answer it.*

Data collection – Many sites made the point at how difficult it was to find continence cases as the coding rarely turned up enough to be included in the audit. In fact one of the main points to come out from this audit is that continence coding is inadequate. This meant that sites had to go through the notes one by one to try and find a case that met the correct criteria, this was time consuming and complicated. *We included in the new audit a question on how each case was identified, and used this indicator to promote screening Sites also feedback that they wanted to register which notes were being reviewed (e.g. GP notes versus continence specialist notes) and in what setting for the results to be more meaningful to their organisation so this question was included*

Webtool – Needed to simplify what each health sector needs to answer so that they only see questions they are answering both on the web tool and on paper. *In the new audit there is one common proforma applicable to both acute hospitals and primary care so this issue does not arise*

Care Homes – In general needed more support than the NHS trusts. Care homes reported that by making the audit simpler, shorter and less medical they would find the audit easier to complete. *The care home audit tool in the new audit meets those criteria (was developed by a care home subgroup of the NACC steering committee and reviewed by people working in care home) and is paper based*

Pilot audit web tool design

The web tool was designed so that each site logged on with a unique password and site code. Once logged on sites had access to information that would take them through the whole audit process and the data entry facility.

In the webtool they could read and download the webtool user notes, audit help notes, audit sample information as well as print out paper versions of the audit. We provided a constantly updated 'Frequently Asked Questions' section during the pilot audit. There were also functions available for once the audit was complete, including the ability to print out a short report covering the key indicators and exporting all their audit data on an excel spreadsheet.

The webtool allowed us to see who had logged on and when, this helped us to monitor how far participants had got in completing the audit. It meant we could target those who may require further assistance.

The pilot audit help notes provided participants with assistance on each audit question, providing an explanation on what the responses meant as well as the evidence behind why the question was being asked.

The webtool allowed for data to be entered by clicking on either clinical or organisational audit, user could then input all their data at once or complete part and save it and return to it later. The audit webtool page also allowed for comments to be left next to each question. Once completed participants would need to lock the case and this would indicate completion of that case, the audit team could also see this information.

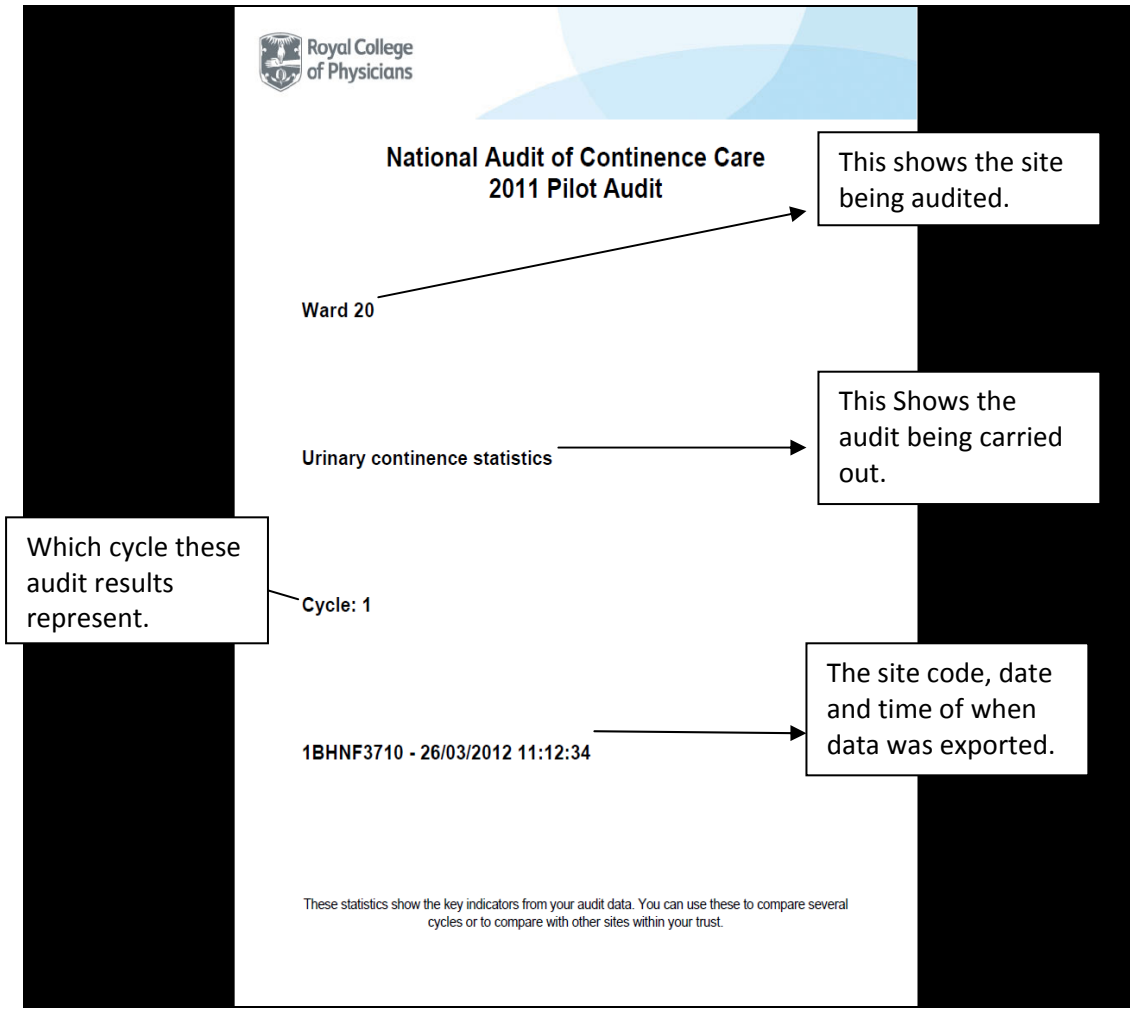
Reporting function

New for this pilot we trialled an export function within the webtool, this gave participants the facility to print out an instant statistics report based on the information they had inputted in to the webtool. This illustrated in table form the data that had been entered by the participant.

Once participants had entered 5 or more sample cases into the webtool they were able to click the statistics button. This provided them with options to view and print out the tables of their key indicator results.
Sites that were registered from within the same organisation could see each others key indicator report. This allowed for instant comparison between sites, which could comprise of comparing two wards.

This new facility would prove particularly useful if the audit was carried out over several cycles or over multiple sites. This would allow participants to compare from one cycle to another. This could be particularly useful when action planning and implementing change.

Below are two example pages from the instant reporting function:

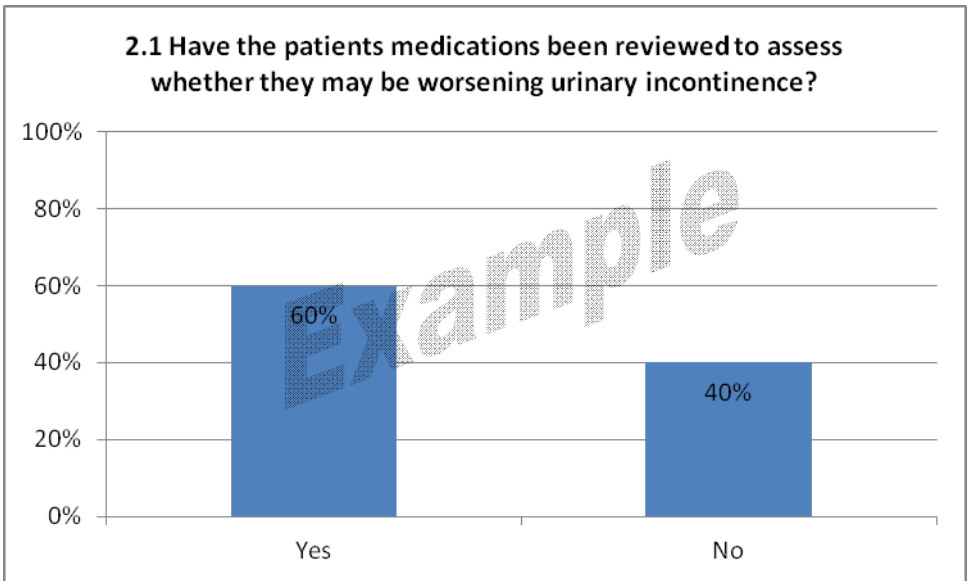


Royal College of Physicians

Management, Assessment / Investigations

2.1	Have the patients' medications been reviewed to assess whether they may be worsening urinary incontinence?	Yes: 60% (3) No: 40% (2)
2.2	Have medical conditions that may be relevant to urinary incontinence have been reviewed (e.g. diabetes, heart failure, reduced mobility, neurological conditions)	Yes: 100% (4) No: 0% (0)
2.3	Has the patient's functional ability been assessed? Over 65	Yes: 100% (5) No: 0% (0)
2.5	Has the impact of incontinence on quality of life been assessed?	Yes: 60% (3) No: 40% (2)
2.6	Has an assessment been performed focussing on finding the cause of urinary incontinence?	Yes: 100% (5) No: 0% (0)
2.7c	Is there documented evidence of examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy	Yes: 67% (2) No: 33% (1)
2.7d	Is there documented evidence of examination of PR to examine prostate size	Yes: 100% (2) No: 0% (0)
2.8c	Is there documented evidence of urinalysis	Yes: 100% (5) No: 0% (0)

At present sites can print out and save their key indicator results in a table form, in the future the audit team could provide participants with their key indicator results in graph form below:



Care home audit tool

In previous audits we have received feedback from care homes informing us of the difficulties they have sometimes had with the online webtool. We have therefore made the webtool simpler to use and access, and added more information to our webtool help notes.

We also provide participants with the ability to print out a paper copy to make it easier to collect the resident's data. Participants were able to take the paper copy around the home with them and write in the answers to the questions. Once they had completed the paper copy they would input the data onto the webtool and submit.

Some care homes did have problems accessing the computers to input the data, and during this pilot we provided assistance and inputted the data ourselves. This is unfortunately something we could not provide on a large scale due to the time consuming nature and cost.

Pilot audit recruitment and participation rates

Recruitment of sites

This pilot audit included significantly new content and innovative functionality, so we recruited a higher number of sites than in previous pilot audits. Organisations were invited to participate via continence lead and clinical audit contacts known to NACC from the 2010 audit, as will as via the NACC newsletter and NACC regional workshops. Care homes were contacted from previous audits as well as via members of the steering group. Many organisations showed interest in participating, although some were not able to take part due to staff and time problems.

Organisations were asked to register 2 sites within their trust (e.g. different wards or GP surgeries) so that they could compare them for their own purposes. Once organisations had registered, the NACC team provided them with login details for each of their sites. These were then linked on the webtool so that whichever login was used participants would be able to see both their registered sites.

The following table illustrates the number of pilot sites that registered; were withdrawn or did not submit, and the number that did submit data using the web tool.

Table 1: Recruitment and numbers submitting data

Recruitment and numbers submitting data	Acute (inc. mental health trusts)	Primary care	Care homes	Total
Registered	88	32	24	144
Withdrew or did not submit any data	28	9	15	52
Submitted organisational data	39*	15*	8	62
submitted clinical data	60	23	9	92

*Sites were given the choice to enter 1 organisational data for both registered sites or 1 for each site.

Method and data collection

Acute and primary care trusts

Acute and primary care organisations were asked to complete an organisational audit, a bladder clinical audit and bowel clinical audit. Participants were asked to identify patients who had urinary and/or faecal incontinence by going around wards or looking through outpatient or primary care case notes. 5 patient samples per site each for bladder and bowel care and 2 cycles were requested. Participants only had 2 months from 1 November to 31 December 2011 to input data,

Care homes

Care homes were asked to complete one organisational and one clinical audit for bladder and/or bowel problems. They needed to identify at least 10 customers in the care home with continence issues. The details of these customers should then be entered into the webtool.

Cycles

It was acknowledged that because of the short 2 month time frame, the cycles would only be meaningful in testing the technology and giving sites a feel for the continuous quality improvement

modality. We asked participants to choose two separate cycles so that this particular function of the webtool could be tested and evaluated.

Data collection forms

Hard copy versions of the webtool were made available to download. These were designed so that people could use them to collect the data as they went around the wards/care home. Participants had the choice of entering the information directly on to the webtool or using these paper proformas first and then in puting the data online. The audit tool proformas can be found in the **appendix** 2.

Help notes

The project team and steering group members worked to provide a comprehensive set of help notes on each of the audit questions. This resource went through question by question giving the evidence behind each question and why we were asking it. It also provided assistance on how to answer the question and what each response meant. Below is an example page from the audit help notes.

INVESTIGATIONS			
	Question	**Evidence behind the question**	**Answering the question – what do the responses mean**
2.8	Have the following tests been documented:		
2.8a	• Renal function		
2.8b	• Post void residual volume	**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).	Is there any documentation that a post void residual volume has been measured? This will usually (and ideally) be done by hand held bladder scan, but may also be done by in and out catheterisation in the absence of a bladder scanner.
2.8c	• Urinalysis	**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.	The result of a urinanalysis should be noted within the focussed continence assessment for this question to be answered yes

Key indicators

The key indicators are the questions within the pilot audit that the national audit of continence care steering group decided were the most relevant/important. The key indicators cover areas of patient/resident care and service that should be provided. In the full results section these are highlighted in the tables by the shaded questions.
In this pilot the key indicators were those questions on which sites received instant feedback in our web tool reporting function.

Evaluation of the pilot audit

Feedback from participating providers

The feedback received on the pilot audit was on the whole positive both in terms of usability and content. Providers saw value in using this audit tool [1] to change and improve practice and [2] to aid training and development
Any negative comments received from participants were requests for better explanations of the new functions of the tool.

- 85% thought that they could use this tool to continuously quality assess their service
- 66% believed they could use the audit information to action change
- 76% also saw value in this audit as an educational tool, especially within their own teams
- Care homes participating in the pilot fedback that this tool could be used on a regular basis to audit care, improve quality and prompt care planning

NHS trusts (acute hospital, primary care and mental health)

- Significant improvement (having previously done 3 past audits)
- Tool is excellent and found it very easy to understand and user friendly
- It made us more aware what actions need to be taken
- I can always tell health care professionals (HCP) what is required to document when assessing patients with bladder/bowel problems especially during teaching sessions
- It could be used to action change if done regularly and re-audits are carried out to assess sustained/ improved care
- It would help us to improve the assessment process. Highlight areas for development and encourage evidence based practice
- Our site does not have a dedicated continence advisor therefore as a nurse practitioner I am currently looking at improving services for elderly patients on the care of the elderly wards, looking at utilising nurse practitioners to improve assessment and management in this area therefore any audit work is extremely beneficial
- The instant reporting and cycle element of the audit need to be explained better

Care homes

There was positive feedback on the new audit content, especially in comparison to previous audits.

- The language used was an improvement and it was less medically orientated.
- Simpler and quicker audit
- Something that we could use on a regular basis to audit our residents
- it is a very good prompt tool for care planning
- This would be good for guidance on how to record information on continence care in residential homes, as we just follow instruction from continence nurses without knowing why customers have a continence problem

Those who did not complete the audit

We contacted sites who did not complete the audit and this is the feedback we received. Reasons given included time constraints, staff difficulties and sickness. Care Homes that did not complete the audit gave feedback on the audit as well as the reasons why they were not able to complete it. This feedback was mostly positive with the system and audit being described as user friendly and simple to complete. Two sites told us they would be willing to participate next time. The reasons behind non completion were mostly linked with lack of access to computers or staff shortages and difficulties.

What went well and what revisions are needed

	What went well?	What did not go well?	What revisions and why?
Aims and purpose of pilot audit	This was a larger pilot audit than carried out previously due to enthusiastic take up by volunteering sites. The majority of the participants understood that this pilot was to serve multiple purposes; -Test new webtool functions -Feedback on shorter more concise questions -Audit patients / residents	Some did not fully understand that we wanted to evaluate all the different functions as well as collecting the data. This included some participants being unaware that the extra reporting function existed.	Provide better, fuller and more precise explanations of the purpose of the audit. Explain all features available and provide participants with help notes in each of the webtool functions available for use.
Audit planning and time	83 organisations (acute, primary care and mental health care trusts) participated despite challenging timescales.	There was initial confusion over whether this was a 'pilot audit' or the full national audit.	This will evidently not be an issue when the actual national continence care audit (NACC) is launched. We will however need to clarify to sites that the NACC will have 2 purposes: [1] Providing them with a continuous audit tool that allows them to enter data at any time in to the web tool, perform a 'local' audit, look at their results, identify action required, implement and then re-audit to see if their actions have improved care. [2] Once a year (between predefined dates) the audit team will in addition run a national audit - we will analyse these data, prepare local site reports and a

	What went well?	What did not go well?	What revisions and why?
			national report for benchmarking and executive purposes.
	Due to the changes made to the audit, this pilot proved less time consuming. While some care homes were unable to complete the audit, reasons for non completion were related to organisational issues rather than the pilot audit.	Staff changes and cost cutting meant some organisations that had registered had to withdraw during the pilot process. 26 care homes registered to participate in the pilot audit, but 15 of these did not complete the pilot audit. We followed up with these care homes to find out reasons for non completion. These included: lack of staff time, staff changes and sickness at those particular care homes.	We will ensure that the audit ticks boxes for nationally required metrics (such as catheter-related UTI, now part of a national CQUIN). The ability of sites to continuously audit their practice at intervals chosen by them means that it can be embedded into routine healthcare audit and monitoring. The pilot results showed that many sites did not have any alternate means of auditing continence care (other than our national audit) so this will fill an important quality outcome gap
Audit data collection & Audit forms and questions	Most participants found it easy to complete the organisational and clinical audit forms. Site feedback from the previous national audit indicated that they wanted to register which notes were being reviewed (e.g. GP notes versus continence specialist notes) and in what setting for the results to be more meaningful to their organisation. This was achieved in this pilot. The shorter and more concise audit forms in comparison to previous versions were welcomed. Pilot participants commented	The feedback was that more than 60% found collecting the data for the pilot audit easy. Some did comment that there was some difficulty collecting patient data that we asked for. This was mostly due to problems encountered in the notes, either difficulty interpreting them or lack of information in patient notes.	We requested feedback on ease of use (including wording, need for additional tick boxes etc.) for each audit question in this pilot, and although the recommended changes from participants were minimal, we will incorporate them into the next version. The educational benefit of this webtool as reported by participants will be highlighted, especially as the pilot audit results

	What went well?	What did not go well?	What revisions and why?
	that they could use clinical audit tool in training and case-based discussion. The language used in the pilot audit forms was seen as an improvement as it was less medically orientated (which was particularly welcomed in the care homes).		showed that structured training is suboptimal, especially in the acute setting
Web tool	Most participants found using and accessing the webtool easy. They also made use of the user notes and help notes during the pilot audit. Only 3 sites gave us feedback that they had any problems entering data on the webtool. Data entry on to the webtool proved to be quicker and easier than on previous audits.	The RCP project team were frustrated that the webtool would not allow incorrectly entered cases to be deleted. It would be useful to be able to sort cases on the admin screen on the webtool. This function would allow for quicker identification of sites that may be having problems with data entry. It was often difficult to see which sites within an organisation were linked together.	Make changes to the webtool alongside webtool administrator to ensure it is updated so that cases can be deleted, but with safeguards. Link the 'sites' that have been flagged up as one organisation, to make it easier to administer and provide assistance with audit completion.
New functions on webtool	We piloted 2 main new webtool functions. First was carrying out more than one cycle. Second was providing an instant statistical report of the key indicators. On the whole both of these worked well.		
Audit cycles function	This element allowed for organisations to compare their service over a set period of time. This facilitates completing audit cycles and therefore is meant to help with action planning and service improvement. It was a welcomed addition and participants reported that they could effectively use the	Because of the short time period for running this pilot, we could not make full use of this facility, though the pilot version did seem sufficient for people to feedback favourably.	The audit cycle function will be developed further so that participants can easily date and number their cycles. We will improve on all the technological shortfalls as highlighted by feedback received

	What went well?	What did not go well?	What revisions and why?
	tool to improve practice.		from participants. We will explore the option of instant graphic reports (e.g. histogram) in addition to tabulated data. Improve the technical elements of the webtool to make it as user friendly as possible.
Instant reporting	We received mostly positive responses to the new instant statistic reporting function. Over half of the participants used the reporting function. The majority found it easy to use and that the information provided was useful.	Some participants did have reservations with using this function. These included difficulties with the PDF format, the inability to compare against a national average, the system not picking up all their data and a technical issue regarding the size of the window that was difficult to enlarge.	
Pilot audit results	The results gave a meaningful profile of both organisational and evidence-based continence care. Areas of suboptimal practice were effectively highlighted. The audit successfully measured variability across sites.	A small number of questions scored 100% or close to that across the board. This indicates that these questions need to be reviewed or expanded further.	100% questions will be reviewed by asking sites how they were answered, and revised.
Using audit in future / action planning	Many organisations commented that this is something they could use on a regular basis to audit their quality of care. Some saw it as a good prompt for care planning. It made may participants aware of the actions they need to take. The majority of respondents said that they could use this audit to continuously assess the quality of their service if it were available at all times. It could be used to action change if done regularly and re-audits are carried out to assess sustained / improved care by highlighting areas for development and encourage evidence based practice.		This is a powerful aspect of this webtool as continuous quality improvement is most effective in improving care standards. To build on participants using the audit as an agent for change, we will encourage them to share change strategies (e.g. assessments, algorithms, policies) with peers via the RCP NACC website.

	What went well?	What did not go well?	What revisions and why?
Learning from the pilot Results	Overall the pilot was successful. The new shorter audit questions were simpler to understand and were more targeted. Participants found the questions useful and the webtool easy to use. The idea behind short cycles of audit, constant access to the audit tool and instant report feedback on key indicators was something that organisations liked and would find useful to improve their quality of service.	The pilot timescale was short and some of the new features could not be tested as thoroughly as hoped. Some organisations felt they had not been given a full enough explanation for the new features, such as auditing over cycles and downloading the instant report function.	The pilot has provided sufficient data and feedback for us to develop a cutting edge national continence care audit, and to prepare a business proposal for audit commissioners.

Pilot audit results summary

In this section the pilot audit results are evaluated, interspersed within the evaluation we have used quotes taken from another element of NACC work, the pilot patient experience questionnaire. The aim of this pilot was to test a questionnaire exploring patient's experiences of their local continence service (bladder and bowel service). A full report evaluating this pilot work is currently being written and will be given to HQIP.

The pilot was run in 83 hospitals and primary care sites, so no firm conclusions can be drawn from these data. However, the participating sites were geographically diverse representing a good cross-section across England and Wales. They also represented different levels of quality in organisational continence care as measured by the 2010 audit: 9 scored in the upper quartile, 29 in the middle, and 7 in the lower. The results do therefore highlight areas of good and poor practice that are overall indicative of the national picture. We present here a summary of the results followed by the full data.

Organisational audit results

54 pilot sites, with submitted data between 31 October 2011 and 5 January 2011, median 8 December 2011. 15 sites were from primary care and 39 from acute secondary care.

Policies
Written polices for continence management were non existent in almost half of the acute NHS sites. This is consistent with our previous audit data and reflects the lack of integration in continence care in the acute care setting as shown in the 2010 NACC.

Quality indicators
Quality indicators for catheter-acquired Urinary tract infection (UTI) were present in two-thirds of all sites, reflecting current national drivers for documenting Catheter associated urinary tract infection (CAUTI) rates (national CQUIN, Quality, Innovation, Productivity and Prevention (QIPP)). Quality indicators for urinary and faecal incontinence were less evident. NHS organisations require a reliable way of capturing data to support development of continence quality indicators, and we designed this NICE-based audit with this requirement in mind.

Commissioning
Commissioning of continence services in primary care was reported as 80% primary care trust (PCT) and 20% GP consortia. Evidently this will be changing with the Health and Social Care Reform bill, and this audit can continue to chart this change.

Continence nurse specialist workforce issues
The pilot organisational audit showed that the number of FTE continence nurse specialists had actually fallen in the previous 12 months in 27% of primary care sites and 18% of acute sites, while the clinical audit showed that continence nurse specialists are delivering the majority of continence care. These data can be used for local business planning. Nationally speaking, measuring the impact of the Health and Social Care Reforms (continence care comes under the umbrella of Any Qualified Provider) and NHS efficiency savings on continence care commissioning and service delivery is essential, and no other audit is currently able to do this.

Staff Training
Structured programmes for staff training were non existent in 54% of acute Trusts. Although staff training was present in all primary care sites, these largely served nursing staff, with only a quarter of programmes targeting doctors. This links in with the lack of GP involvement shown in the clinical part of

this audit, where none of the continence assessments in primary care were done by GPs. With continence nurse specialists being flagged up as a vulnerable resource as above, this raises concern for the delivery of continence care in the community. This also demonstrates how different aspects of this pilot audit can be joined up to show the 'bigger picture'.

Organisational approach to screening and care pathways
The majority of sites used a screening question relating to bladder and bowel problems in their routine clinical practice. The next question however looked at continuity of care and showed that 40% of acute sites did not have an existing care pathway to be initiated when a patient answers yes to the screening question. Also, half of acute sites did not offer a continence assessment at the point of providing people with pads for the first time. Most primary care sites did offer this assessment, though it would be of interest to see how thorough the assessment is.

Privacy and dignity
As per the 2010 results, most organisations reported that their environments provided privacy (within the largely unavoidable limitations of curtained off beds in acute hospital wards). Patients using commode or bedpans by their beds were not always offered hand washing after toileting in one-fifth of sites – organisations could easily use the continuous audit facility of this pilot to get important dignity practice points such as this right.

'I found that this difficult problem was dealt with great sensitivity and understanding. Before the meeting I was very apprehensive but left feeling very reassured. I would not hesitate to consult the team again if I needed further help and advice.'

Provision of pads and products
While 53% of primary care and 26% of acute care sites reported a daily limit for continence products, only 13% and 3% respectively said that products were supplied on the basis of cost rather than clinical and patient need. This is an important but complex indicator (linking to both quality of care and commissioning imperatives) that successive audits would monitor.

Patient experience
The minority of continence services had dedicated user groups (31% primary care, 19% acute), but the comments we received showed that continence services are working with users in various other ways (e.g. via MS or dementia groups). 86% of primary care and 69% of acute care sites reported that they audited patient experience as an aspect of continence care and we plan to follow up with them to see if this is generic (as per existing CQUIN) or specific to continence. We have successfully tested a patient questionnaire in parallel to running this pilot audit, with good engagement from provider sites and users and have included italicised patient quotes from our patient experience (such as the one above and below) throughout this report .

'I battled for nearly 3 years before I was referred to the continence service. My doctor told me I would have to learn to live with it. This was the bowel, I also had bladder incontinence. I credit X as my life saver if I had been referred to this department by my doctor it would have saved me from clinical depression. I just felt nobody wanted to know.'

Patient choice in types of products (viewed as important for dignity by user groups) was limited in 27% of primary care and 69% of acute care sites.

'I was given a wide choice of CIC catheters to choose from - excellent service of care'

Organisational approach to continence care audit
Sites reported that the National Audit of Continence Care has been primarily used to audit bladder and bowel care, emphasising the need to establish ongoing funding. Most ran catheter care audits. Sharing examples of good audit and practice between sites via the RCP NACC website is integral to aims of the National Continence Care audit.

Clinical urinary incontinence audit results

Demographics
The majority (84%) of patients audited in acute care were aged 65+, so the pilot in that setting largely tests continence care audit in older people. The primary care group were younger (65% aged 65+). About two-thirds of cases were women in both settings.

Who performed the audit?
Participants from primary care in the 2010 audit requested that we allow them to identify which notes were being audited. In this pilot, only 3% were GP notes 62% continence nurse records, and 35% hospital notes. Acute care cases were largely medical (35%) and elderly care (49%) inpatients, so the pilot in that setting largely audits care delivered by non-specialist hospital ward staff.

How were cases identified?
Another new question asked how cases were identified for this audit. In primary care 40% had sought help for the problem and 29% picked up through routine screening. 52% of cases in acute care were identified through routine screening but 25% were only identified through case-finding for this audit. So the pilot audit served to increase case identification in acute care, which is not ideal, but the idea is that through successive audits providers should aim to pick up more through their routine screening. We emphasised this in our help notes, where we explained the reason behind every question in the pilot audit (**see appendix).**

'Doctors and nurses should talk to me about my continence problem.'

Were patients fully assessed?
The pilot asked if an assessment was performed focusing on finding the cause of urinary incontinence. 24% of cases in primary care, and 49% in acute care had no such assessment documented. Where there were assessments in primary care, none were done by GPs, 72% by Clinical nurse specialist (CNSs), 12% by district nurses and the remainder by hospital staff. In the acute setting the CNS had done 24% with rest conducted by hospital staff.

Were urinary symptoms documented?
One quarter of acute care patients did not have any urinary symptoms recorded; the question documenting urinary symptoms included all symptoms that should be asked about, hence reinforcing good practice and promoting use of this audit as a training tool for non specialist staff. Bladder diaries were underused (46% primary care, 18% acute), though participants rightly pointed out that the audit question did not allow them to identify patients unable to complete them due to cognitive impairment, and this will be corrected.

Were patients adequately examined?
A low proportion of men had a digital rectal examination to examine prostate size (13% in primary care, 29% in acute care) and for women, only 42% in primary care and 31% in acute care had an examination of the perineum and pelvis to identify prolapse, excoriation and urogenital atrophy. Generally these examinations would be undertaken by doctors (non specialist e.g. ward staff, GPs), CNSs or link continence nurses (in hospital or community) trained to do so by CNSs. Sites can therefore use these data to improve training and practice.

How well were the causes of urinary incontinence documented?
Documentation of the cause(s) of urinary incontinence was 81% in primary care and 53% in acute care. We highlighted this point in our 2010 audit report, that suboptimal assessment leads to under diagnosis and to under treatment.

Did patients receive appropriate treatment and follow up?
Indeed, only 79% of primary care and 56% of acute care cases had a treatment plan recorded in the notes. Where it was recorded, specific conservative treatments such as fluid advice, pelvic floor exercises and bladder retraining were used in a high proportion of cases. We incorporated these treatment approaches in the pilot as they can be delivered by non specialist staff with simple continence training and use of the audit could reinforce this. Clear documentation of follow up within the treatment plans was absent in 39% of cases in primary care and 59% in acute care. The helpnotes point out that lack of follow up promotes containment rather than cure, and this can undermine patient confidence in coping with this distressing problem.

'I was not given any continence products. But was given leaflets and advice on how to manage my continence. I also received a follow up phone call at home.'

Reviewing medications and medical conditions that may be worsening incontinence is part of basic management, and all the more important in older people who are likely to have many comorbidities and be taking multiple drugs. Medication review was documented as done in 64% of cases in primary care and 47% in acute care. In both settings, a third of cases in whom medications were reviewed had drug alterations made, reinforcing the value of this clinical indicator. In acute care, 78% of patients had a review of medical conditions relevant to incontinence, with 70% of these having their condition optimised as a result (diabetes, and diet-related conditions were given by as examples).

Catheter use
This new audit asked more focussed questions on catheter care in view of quality and policy drivers in the NHS to reduce inappropriate catheterisation. Catheterisation rates in the community was 6%, consistent with national benchmark. Twenty-one percent of acute cases were catheterised, which initially seems to be high – but on further questioning in the pilot, 90% had a reason for insertion documented, with the reason being appropriate against national guidance. This section of the pilot audit can serve sites well as an 'off the shelf' way of monitoring catheter use.

'Why is it that when an emergency catheter is fitted there is no follow up. District nurses should have changed bag but didn't. Now taking antibiotics in the hope my kidneys are not damaged.'

Was urinary incontinence linked with urinary tract infection and pressure sores?
Another new question measured consequences of urinary incontinence, again providing sites with for quality and cost data to be used in routine clinical governance. Urinary tract infection was documented in 14% of primary care and 26% acute, urosepsis 0% and 5%, and pressure ulcers 2% and 7%.

Assessment of quality of life, shared goal setting and communications with patients
Impact of continence on quality of life was assessed in 69% of primary care and 25% of acute care patients, similar proportions to those in whom patient own goals had been documented. Treatment plans were given to the patient in 57% of cases in primary care and 25% in acute care, despite the audit question providing options common in clinical practice such as patient letter, discharge summary, information leaflets. We feel there is much more work to be done to improve communication with patients and have undertaken a parallel patient project to inform people of what they should expect from NHS continence services (with patient focussed booklet reporting on the audit, and a specific patient questionnaire).

'I was explained fully about being incontinent. I felt at ease without being embarrassed.'

Clinical faecal incontinence audit results

Demographics, auditor profile and case-finding
Age and gender demographics, and notes provenance were similar for faecal incontinence so again, the acute care setting mainly piloted the audit older patients on medical and elderly care wards, and younger patients in CNS run service in primary care. Identical case finding issues were also found, with 54% in acute care identified through routine screening, but 27% were only identified through running this audit.

Were patients fully assessed?
Assessment focusing on finding the cause of faecal incontinence was undertaken in 84% of cases in primary care, and 58% in acute care. As with urinary incontinence, none of the primary care assessments were reported as having been done by GPs.

'I feel doctors should be made aware of the importance of this service to the patients. If my doctor had referred me instead of putting me on anti depressants.'

Were bowel symptoms documented?
One quarter of acute care patients did not have any faecal incontinence symptoms recorded, The question documenting (faecal incontinence) FI symptoms likewise reminded providers of good practice by including all symptoms that should be asked about. Stool charts were used in 69% in primary care, 74% in acute, with 39% versus 94% provider completion, again reflecting the different case load in the 2 settings.

Were patients adequately examined?
Only 50% of cases in primary and 59% in acute care were documented as having a digital rectal examination (DRE). Our NICE-based help notes explain that DRE (in patients who consent) is essential to look for cancer, anorectal conditions, and stool impaction. Non specialist nurses (e.g. ward staff) can do DREs to assess impaction according to RCN guidance. This is a simple continuous audit indicator that sites can use to practice safe care.

How well were the causes of faecal incontinence documented?
Documentation of the cause(s) of faecal incontinence was 64% in primary care and 52% in acute care. Functional/cognitive cause was documented in 44% of cases in the acute setting – our helpnotes emphasis that such frail older patients are at greater risk of overflow faecal incontinence (which is treatable) and should still have an appropriate examination.

Did patients receive appropriate treatment and follow up?
84% of primary and 62% of acute care cases had a treatment plan recorded in the notes. Where recorded, specific treatments in primary care focussed on sphincter damage while in hospital treatment of diarrhoea and constipation predominated. Follow up plans were evident in 69% of cases in primary care and only 35% in acute care.

Medication review was done in 80% of cases in primary care and 52% in acute care with 61% and 53% respectively of cases in whom medications were reviewed having drug alterations made. In acute care, 69% of patients had a review of medical conditions relevant to faecal incontinence, with 66% of these (70% in primary care) having their condition optimised as a result. Function and cognition was assessed in 80-89% of patients across the board - this has always been an indicator in the National Continence Care audit and has improved with successive cycles.

Was faecal incontinence linked with urinary tract infection and pressure sores?
Urinary tract infection or urosepsis rate was 9% primary care, and 22% acute, 12% of acute patients had pressure sores (2% in primary care). The inclusion of this new indicator in the pilot is because better bowel care (treatment of overflow, use of bowel manager etc.) may reduce this costly and painful complication, plus pressure sore incidence is also now a national CQUIN measure.

Assessment of quality of life, shared goal setting and communications with patients
Impact of faecal incontinence on quality of life was assessed in 69% of primary care and 20% of acute care patients. Documenting patients own goals and decisions on treatment are NICE recommended and was evident in 60% of primary care and 25% of acute care patients.

'We made a plan of action together which so far has been successful'

Participants highlighted that a tick box for unable due to cognitive impairment should be added, so the lower % in acute care is partly due to case-mix. Treatment plans were given to the patient in 67% of cases in primary care and 17% in acute care. Carers (where relevant) received this information in 36% and 27% respectively. It is very useful for people caring for individuals with chronic faecal incontinence to have information on bowel care.

Long-term faecal incontinence management and advice on self-management (e.g. laxative or loperamide use),continence products, skin care, odour control, preservation of dignity and independence and contact details for support groups/helplines (e.g. Bladder and Bowel Foundation)is strongly recommended in the NICE guidance and was given to 64% of patients in primary care and 18% in acute care.

'I think the whole subject should be made more public and more advertising about continence and the number of people it effects. Many people feel isolated and alone because they have continence problems. Why does the benefits system not cover urinary incontinence as a disability? This is so unfair.'

Care home audit results

Nine pilot care homes returned data so these results really only serve to test the pilot questions rather than to document the stats of continence care in care homes nationally.

Organisational results

Access to Continence Nurse Specialists and GPs
Participating care homes reported reasonably rapid access to CNSs and GPs following referral. Of note, the recent CQC report on care homes ('Health care services for care home residents report', March 2012) flagged up that nationally access to CNSs was inadequate.

Staff training
38% have a structured programme for managing continence problems - training reinforced by continuous quality improvement through audit could improve this. This pilot went further in defining how training was delivered: the training was one off (such as at induction/starting at care home) in 63% with only 38% running more effective rolling programmes (annual refresher or different sessions over time).

Organisational approach to screening and care pathways
75% of care homes said they ask a screening question relating to bladder and bowel problems as part of the admission assessment, but as in acute care, only 50% had a protocol or pathway that is initiated when a bladder or bowel problem is identified.

Provision of pads and products and patient choice
There was evidence on pad restrictions with one quarter reporting that they provided products on the basis of cost rather than clinical and resident need. It is not clear however whether this is an NHS decision, if they provide the products, or a care home decision if they receive the funding from the NHS to purchase their own products for residents, so in the future audit we will ask this. Few residents in care homes had a choice of products available from either the NHS or the care home.

Information provided to residents and families
63% of the care homes provide information about bladder and bowel care to residents and their families.

Clinical results for urinary and faecal incontinence

Demographics and case-finding
There were 68 pilot cases for the pilot bladder care audit, and 16 for bowel care (all aged 65+). No patients were identified as incontinence through this pilot – incontinence was identified either at preadmission assessment or on admission to the care home.

Assessment
Care home reported that bladder and bowel symptoms had been documented in the care plan in 94-100% of cases. We will therefore need to re-examine this pilot question by reviewing with participants how they interpreted documentation of symptoms in the care plan (i.e. does it go beyond noting incontinence and asking about urgency, stress etc.). 60% of residents with urinary incontinence had however completed a bladder diary, 93% had had a urine dipstick test and 56% an mid stream urine specimen carried out in the care home. Half of residents with faecal incontinence has had a stool chart to record frequency of incontinence.

Assessment to find the cause of urinary incontinence was performed in three-quarters of residents. This was done by the nurse in the care home in 21% of cases, district nurse in 27%, GP in 8%, Continence Nurse Specialist in 33% and hospital in 12%. This pilot question informs care homes that continence training should be targeted on care home and district nurses, and clarifies access to CNSs and GP engagement.

Assessment to find the cause of faecal incontinence was done in 69%, but only 38% of patients had documented evidence of digital rectal examination, so the quality of assessment would need review. More care home nurses undertook the bowel assessment (38%) so again the pilot focuses the need for ongoing training.

Medicines and medical conditions (Parkinson's disease was provided as an example) review occurred in 70-80% of cases, with subsequent optimisation in about one-eighth (though in faecal incontinent patients medications were altered in 43%). Cognition and physical function was assessed in almost all cases, with some comments

'This resident is aware of what is going on, she is just reluctant to get up to go to the toilet'. 'This lady is unaware of her condition. She just tends to leave her stools dotted around the home, hidden in various containers.'

How well were the causes of incontinence documented?
The cause(s) of urinary incontinence were recorded in 74% with a comment that *'The report on this is with the continence nurse not us'.* The rate for faecal incontinence was 63%.

Did patients receive appropriate treatment and follow up?
Fluid advice in urinary and faecal incontinence was commonly given. Low rates of pelvic floor exercises and bladder retraining may reflect the cognitive and functional profile of residents, and we need to finesse the pilot question to identify this. 13% of patients with urinary incontinence were catheterised – this question was designed to pick up excessive catheterisation rates. The percentage in this small pilot is reasonable rate against national benchmarking, and the reason for catheterisation was recorded in almost all patients.

Treatment plans were evident in one third of patients with urinary incontinence and two-thirds of patients with faecal incontinence, most of whom were receiving laxatives. More clarity may be needed for this pilot indicator as to what is a treatment plan and what is a care plan.

Nearly all care plans contained information on maintaining privacy in continence care, skin care, checking for signs of urinary infection, ensuring resident eats and drinks enough to help with continence, and recognise signs or provide advice of when the resident likes to go to the toilet. This pilot audit question is an example of the value of developing a tool that is specific to continence care in care homes.

Only 1 patient was using urinary incontinence products other than pads (such as urinary sheaths), and this is a practice point highlighted by the pilot that care homes can work on.

Was incontinence linked with urinary tract infection and pressure sores?
This new question prompts thinking about consequence of incontinence. Only 3% of patients with urinary incontinence were reported as having pressures sores e.g. *'This lady has a split on her sacrum which the district nurse is dressing and observing regularly.'*

Assessment of quality of life, shared goal setting and communications with patients
The pilot audit asked about impact of incontinence on quality of life areas appropriate to care home residency, such as social isolation, low self-esteem, missing activities in the care home, missing trips out. This was reported as having been assessed in the majority of cases *'Up until recently he still went out on bus trips even though he has always been frail whilst living with us.'*

Resident's choice or decisions were documented as recorded in the care plan in 100% for urinary incontinence, so this is another pilot question whose accuracy will be reviewed. For faecal incontinence almost all patients were recorded as not being able to decide on their own goals, but 3 out of 4 of those that could, had their choices recorded.

Full pilot audit results

The key indicators are the questions within the pilot audit that the national audit of continence care steering group decided were the most important. These are highlighted in this report by the shaded questions.

Organisational audit result for NHS trusts

1. Policies and Commissioning

Table 2:

Question	Primary care	Acute
1.1 Do you have a written policy for the management of continence (in your GP practice/ hospital /care home)?	100% (15/15)	56% (22/39)

Table 3:

Question	Primary care	Acute
1.2 Does this written policy include directions on:		
1.2a Training for staff in delivery of continence care	87% (13/15)	82% /(18/22)
1.2b Assessment and treatment of incontinence	100% (15/15)	100% (22/22)
1.2c Shared and agreed pathways of care (across disciplines and care boundaries)	73% (11/15)	86% (19/22)
1.2d Regular audit of continence services	53% (8/15)	64% (14/22)

Table 4:

Question	Primary care	Acute
1.3 Do you have a quality indicator, CQUIN or other relating to:		
1.3a Catheters and/or Catheter associated urinary tract infection (CAUTI)	67% (10/15)	67% (26/39)
1.3b Urinary Incontinence	27% (4/15)	31% (12/39)
1.3c Faecal incontinence	20% (3/15)	23% (9/39)

Table 5:

Question	Primary care	Acute
1.4 What organisation is responsible for commissioning continence services?		
GP consortia	20% (3/15)	13% (5/39)
PCT	80% (12/15)	38% (15/39)
Foundation Trust	0% (0/15)	18% (7/39)
Private industry (for care homes)	0% (0/15)	0% (0/39)
Don't know	0% (0/15)	31% (12/39)
1.4a Does this 'organisation' have a specific commissioning programme for continence?	58% (7/12) 3 NK	80% (12/15) 12 NK

Table 6:

Question	Primary care	Acute
1.5 Is there a lead for continence care or services in your organisation?	100% (15/15)	76% (29/38) 1 NK

Table 7:

Question	Primary care	Acute
1.6 How many continence nurse specialists (CNS)/ specialist continence practitioners are currently employed in your organisation?	Median 4 IQR 3-7 Range 2-13 N=12 3 NK	Median 2 IQR 0-3 Range 0-10 N=27 12 NK
1.6a From the date of completion of this audit - During the last 12 months has the number of Full Time Equivalent continence nurse specialists /specialist continence practitioners:		
Fallen	27% (4/15)	18% (7/39)
Increased	13% (2/15)	5% (2/39)
Stayed the same	60% (9/15)	44% (17/39)
Don't know	0% (0/15)	33% (13/39)

2. Clinical protocols

Table 8:

Question	Primary care	Acute
2.1 Is your practice to always ask a screening question(s) relating to bladder and bowel problems as part of the initial patient/client assessment?	87% (13/15)	95% (37/39)
2.1a IF YES – What is this screening question? ***		
2.2 IF YES Is the screening question:		
2.2a Part of routine nursing assessment?	100% (13/13)	95% (35/37)
2.2b Part of routine doctor assessment?	23% (3/13)	32% (12/37)
2.2c Asked on admission?	85% (11/13)	84% (31/37)
2.2d Asked as part of assessment for pads?	92% (12/13)	54% (20/37)
Comments and feedback		

******* This question subsection shows that when we do request examples or documents of actual practice via the audit sites did respond. 13 primary care sites and 37 acute sites returned examples of screening questions. These few examples give an indication of variability in practice:

Primary care:

1. Are you bothered by your bladder or bowel?

Acute:

1. Any problems with your bowels or waterworks?
2. Do you have any damp pants or experience faecal staining?
3. Medical - Continent, Aids, Incontinent; Nursing - Record normal bladder/bowel function, Record current bladder/bowel function, pads/pants/continence aids used.

Table 9:

Question	Primary care	Acute
2.3 Is there a protocol or pathway that is initiated when a patient responds to the screening question(s) that they have a bladder or bowel problem?	100% (13/13)	61% (22/36) 1 NK

Table 10:

Question	Primary care	Acute
2.4 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?	87% (13/15)	62% (24/39)

3. Investigations / treatment / facilities

Table 11:

Question	Primary care	Acute
3.1 Does your local service have investigation and treatment facilities?	47% (7/15)	95% (37/39)
3.2 Do these investigation and treatment facilities include:		
3.2a Urodynamics	43% (3/7)	97% (36/37)
3.2b Urinary or gastrointestinal tract imaging	43% (3/7)	97% (36/37)
3.2c Anorectal physiology	29% (2/7)	78% (29/37)

4. Training

Table 12:

Question	Primary care	Acute
4.1 Is there a structured **programme of staff training** on promoting continence?	100% (15/15)	46% (16/35) 4 NK
4.2 Does the staff training target:		
4.2a Doctors	27% (4/15)	50% (8/16)
4.2b Nurses	100% (15/15)	100% (16/16)
4.2c Multidisciplinary group (other qualified)	87% (13/15)	75% (12/16)
4.2d Non qualified staff	100% (15/15)	94% (15/16)

Table 13:

Question	Primary care	Acute
4.3 Is the staff training:		
4.3a One off (e.g at induction)	7% (1/15)	19% (3/16)
4.3b Rolling programme	93% (14/15)	81% (13/16)

Table 14:

Question	Primary care	Acute
4.4 Does the staff training create Continence link workers?	53% (8/15)	75% (12/16)

5. Privacy & Dignity

Table 15:

Question	Primary care	Acute
5.1 Do the environments listed always allow for intimate conversations with/examinations/care of patients:		
5.1a Bed area	67% (4/6) 9 NK	58% (22/38) 1 NK
5.1b Toilets	91% (10/11) 4 NK	66% (25/38) 1 NK
5.1c Bathrooms	80% (8/10) 5 NK	70% (26/37) 2 NK
5.1d Outpatient clinics	100% (9/9) 6 NK	89% (33/37) 2 NK

Table 16:

Question	Primary care	Acute
5.2 Are patients/clients who are bed bound and need to use the toilet in the bed or a commode always offered hand washing after toileting?	80% (4/5) 10 NK	88% (22/25) 14 NK

6. Audit

Table 17:

Question	Primary care	Acute
6.1 Is there a regular audit of bladder or bowel care?	93% (14/15)	67% (26/39)

Table 18:

Question	Primary care	Acute
6.2 What aspect of the bladder or bowel care is audited:		
6.2a Catheter use	79% (11/14)	85% (22/26)
6.2b Assessment and treatment of urinary incontinence	64% (9/14)	69% (18/26)
6.2c Assessment and treatment of faecal incontinence	50% (7/14)	58% (15/26)
6.2d Privacy and dignity	50% (7/14)	69% (18/26)
6.2e Patient experience	86% (12/14)	69% (18/26)

Table 19:

Question	Primary care	Acute
6.3 Does the continence service have a user group?	31% (4/13) 2 NK	19% (5/26) 13 NK

Table 20:

Question	Primary care	Acute
6.4 Does the continence service user group:		
6.4a Provide support for other users and or carers	25% (1/4)	40% (2/5)
6.4b Inform service delivery	100% (4/4)	100% (5/5)
6.4c Review patient educational materials	100% (4/4)	50% (2/4) 1 NK

7. Continence products

Table 21:

Question	Primary care	Acute
7.1 Is there a daily limit for continence products?	53% (8/15)	26% (10/39)

Table 22:

Question	Primary care	Acute
7.2 Are products supplied on the basis of clinical and patient need rather than cost?	87% (13/15)	97% (38/39)

Table 23:

Question	Primary care	Acute
7.3 Is a continence assessment and care offered at the point of providing people with pads for the first time?	87% (13/15)	49% (19/39)

Table 24:

Question	Primary care	Acute
7.4 Do patients have access (on the NHS) to the product of their choice such as washable briefs?	73% (11/15)	31% (12/39)

8. Patient Carer Information and Support

Table 25:

Question	Primary care	Acute
8.1 Is evidence-based information about bladder and bowel care freely available to patients and carers?	93% (14/15)	72% (28/39)

Urinary incontinence clinical audit case note review

Audit information

There were 188 cases from 23 primary care sites (median 9, IQR 6-9), 416 from 58 acute secondary care sites (median 8 IQR 5-10) and 8 from 2 mental health sites. For this report these 8 mental health cases have been combined with acute care, to form a total 424 'acute' cases.

29% (54/188) of primary care and 33% (139/424) of acute care patients were male.
65% (123/188) of primary care and 84% (356/424) of acute care patients were aged 65 and over.

Clinical setting for primary care:

- Hospital medical ward (4%, 7)
- Hospital surgical ward (34%, 63)
- Hospital elderly care ward (31%, 58)
- Hospital outpatient clinic (1%, 2)
- Community clinic (19%, 35)
- Care home (2%, 4)
- Other (13%, 19)

Others: District Nursing (9), Home/ home visit/ self- referral from home (10)

Clinical setting for acute care:

- Hospital medical ward (35%, 149)
- Hospital surgical ward (0%, 0)
- Hospital elderly care ward (49%, 207)
- Hospital outpatient clinic (5%, 23)
- Community clinic (6%, 26)
- Care home (0%, 0)
- Other (4%, 19)

Others: Hospital rehabilitation ward (10), Hospital mental health older adults (5), stroke rehab unit (2), stroke ward (1), Graham ward (1)

Notes audited for primary care:

- Hospital notes (35%, 65)
- GP notes (3%, 5)
- Continence specialist records (62%, 116)
- Care home care plan (1%, 2)

Notes audited for acute care:

- Hospital notes (93%, 394)
- GP notes (0%, 0)
- Continence specialist records (7%, 30)
- Care home care plan (0%, 0)

How was urinary incontinence identified for this audit case/person in primary care:

- Routine screening by a provider (29%, 55)
- Patient sought help for the problem (40%, 76)
- Was only identified through case-finding for this audit (6%, 12)
- Other (21%, 39)
- Not known (3%, 6)

Others: Referred by Gp (10), taken off clinic rota (7), Hospital/ward admission (4), District Nursing notes/assessment (3), Staff (3), MS Nurse Specialist (2), already on pad delivery (1), came out of hospital with catheter after failed TW (1), carer sought help (1), Identified by Learning Disability Nurse (1), Referral by Parkinson's Nurse Specialist (1), referral for learning disability nurse (1), referral from physiotherapist (1), Self-referral (1), Transferred with catheter in-situ (1), ward admission post stroke (1).

How was urinary incontinence identified for this audit case/person in acute care:

- Routine screening by a provider (52%, 219)
- Patient sought help for the problem (17%, 74)
- Was only identified through case-finding for this audit (25%, 106)
- Other (5%, 20)
- Not known (1%, 5)

Others: Admission (1), By GP due to symptoms prior to admission (1), by passing long-term catheter (1), carer referral (1), Family concern - new urinary incontinence (1),Identified by nurses when patient on ward (1),Identified following hospital admission (1),MDM (1),new problem as inpatient (1),Not recorded (3), Nurses informed of incontinence on admission (2), Nursing Home informed hospital on admission (1),Patient informed nurse on admission (1),referral (1),Referred by ward staff (1),Referred by ward staff to CNS for continence (1),Therapy Notes (1).

1. Symptoms

Table 26:

Question	Primary care	Acute
1.1 Has the patients urinary symptoms been recorded in the notes?	90% (169/188)	77% (326/424)
1.2 Have the following symptoms been asked about:		
1.2a Urinary frequency?	72% (122/169)	60% (196/326)
1.2b Urgency?	72% (122/169)	44% (145/326)
1.2c Stress?	66% (112/169)	32% (105/326)
1.2d Voiding difficulties?	71% (120/169)	44% (142/326)
1.2e Nocturia?	75% (127/169)	45% (146/326)
1.2f Pain on urination?	54% (91/169)	47% (152/326)
1.2g Constipation?	73% (124/169)	56% (181/326)
1.2h Faecal incontinence?	72% (121/169)	49% (159/326)

Table 27:

Question	Primary care	Acute
1.3 Has the patient completed a bladder diary?	46% (87/188)	18% (76/424)

Table 28:

Question	Primary care	Acute
1.4 Has the patient completed a three day bladder diary?	42% (56/134)	17% (48/285)

2. Management / Assessment / Investigations

Table 29:

Question	Primary care	Acute
2.1 Have the patients' medications been reviewed to assess whether they may be worsening urinary incontinence?	64% (120/188)	47% (199/424)
2.1a Have any such medications been altered as a result of this review?	36% (43/120)	32% (64/199)

Table 30:

Question	Primary care	Acute
2.2 Have medical conditions that may be relevant to urinary incontinence been reviewed (e.g. diabetes, heart failure, neurological conditions)	66% (93/141) 47 Patient does not have any coexisting medical conditions	78% (247/315) 109 Patient does not have any coexisting medical conditions
2.2a Have any such medical conditions been optimised as a result of this review?	49% (46/93)	70% (174/247)

Table 31:

Question	Primary care	Acute
2.3 Has the patient's functional ability been assessed?	86% (161/188)	89% (377/424)

Table 32:

Question	Primary care	Acute
2.4 Has the patient's cognition been assessed?	78% (146/188)	85% (362/424)

Table 33:

Question	Primary care	Acute
2.5 Has the impact of incontinence on quality of life been assessed?	69% (130/188)	25% (106/424)
2.5a Has Quality of Life been recorded by standard assessment (e.g. Kings Health Questionnaire)	64% (83/130)	44% (47/106)

Table 34:

Question	Primary care	Acute
2.6 Has an assessment been performed focusing on finding the cause(s) of urinary incontinence?	76% (143/188)	51% (215/424)
2.6a IF YES: Who did this assessment?		
GP	0% (0/143)	1% (2/215)
Practice nurse	0% (0/143)	0% (0/215)
District nurse	12% (17/143)	1% (1/215)
Continence specialist	72% (103/143)	24% (52/215)
hospital ward doctor	5% (7/143)	43% (92/215)
hospital ward nurse	9% (13/143)	13% (28/215)
hospital continence specialist (includes surgeon)	2% (3/143)	18% (39/215)
care home nurse	0% (0/143)	1% (1/215)

Table 35:

Question	Primary care	Acute
2.7 Is there documented evidence of the following?		
2.7a Examination of the abdomen for palpable mass or bladder retention	40% (76/188)	80% (338/424)
2.7b Examination to assess pelvic floor dysfunction	30% (56/188)	17% (71/424)
2.7c Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy (WOMEN)	42% (56/134)	31% (88/285)
2.7d Digital rectal examination to examine prostate size	13% (7/54)	29% (41/139)

Table 36:

Question	Primary care	Acute
2.8 Have the following tests been documented:		
2.8a Renal function	28% (52/188)	81% (345/424)
2.8b Post void residual volume	59% (111/188)	38% (163/424)
2.8c Urinalysis	80% (150/188)	83% (350/424)
2.8d MSU / CSU	29% (55/188)	62% (261/424)
2.8e Abdominal ultrasound	17% (32/188)	14% (58/424)
2.8f Urodynamics	3% (6/188)	10% (42/424)
2.8g Cystoscopy	3% (5/188)	9% (40/424)

3. Treatment

Table 37:

Question	Primary care	Acute
3.1 Is the type or cause(s) of urinary incontinence documented in the notes?	81% (152/188)	53% (223/424)

Table 38:

Question	Primary care	Acute
3.2 What is the type/cause of urinary incontinence?		
3.2a Stress UI	42% (64/152)	25% (55/223)
3.2b Urge UI	51% (78/152)	25% (55/223)
3.2c Benign prostatic enlargement	6% (9/152)	12% (27/223)
3.2d Neuropathic bladder	8% (12/152)	9% (19/223)
3.2e Urinary tract infection	11% (16/152)	28% (63/223)
3.2f Medication side-effect	5% (8/152)	6% (13/223)
3.2g Constipation (causing retention)	14% (22/152)	15% (34/223)
3.2h Functional or cognitive	39% (59/152)	38% (84/223)

Table 39:

Question	Primary care	Acute
3.3 Does the patient have a treatment plan recorded in the notes?	79% (149/188)	56% (236/424)
3.4 Does the treatment plan include;		
3.4a Referrals to another specialist or service	28% (42/149)	38% (90/236)
3.4b Starting treatment	85% (127/149)	68% (161/236)
3.4c Organised follow up	76% (113/149)	57% (134/236)
3.4d Further investigations	32% (47/149)	36% (84/236)
3.5 Does documented treatment include;		
3.5a Pelvic floor exercises	47% (70/149)	22% (52/236)
3.5b Bladder retraining	59% (88/149)	26% (61/236)
3.5c Fluid advice	83% (123/149)	42% (100/236)
3.5d Bladder antimuscarinic medications	21% (32/149)	14% (32/236)
3.5e Alpha blockers or finasteride	5% (8/149)	10% (24/236)
3.5f Prostatic surgery **(MEN)**	3% (1/38)	9% (7/76)
3.5g Urogynaecological surgery **(WOMEN)**	8% (9/111)	16% (25/160)
3.5h Intermittent catheterisation	6% (9/149)	4% (9/236)
3.5i In-dwelling catheterisation	7% (10/149)	22% (52/236)

3.5j Containment – pads	44% (65/149)	52% (123/236)
3.5k Containment – convene, other products	11% (16/149)	9% (21/236)

Table 40:

Question	Primary care	Acute
3.6 Is the patient catheterised?	6% (12/188)	21% (91/424)
3.6a IF YES: Is the reason for catheterisation recorded in the patient's notes?	83% (10/12)	89% (81/91)
3.6b What was the main reason for catherisation?		
acute retention	70% (7/10)	43% (35/81)
chronic retention with renal impairment	10% (1/10)	15% (12/81)
trauma/surgery	10% (1/10)	12% (10/81)
severe medical illness (fluid balance monitoring)	10% (1/10)	16% (13/81)
severe pressure ulcers / wound	0% (0/10)	6% (5/81)
Reason not documented	0% (0/10)	7% (6/81)

Table 41:

Question	Primary care	Acute
3.6c Is there a documented plan for removal of the catheter?	42% (5/12)	51% (46/91)

Table 42:

Question	Primary care	Acute
3.7 What consequences of urinary incontinence does the patient have?		
3.7a Urinary tract infection	14% (27/188)	26% (109/424)
3.7b Urosepsis	0% (0/188)	5% (22/424)
3.7c Pressure ulcers	2% (3/188)	7% (29/424)

4. Treatment /Care Plan and communication

Table 43:

Question	Primary care	Acute
4.1 Has the patients own goals/ decisions for treatment or care been documented?	62% (117/188)	29% (122/424)

Table 44:

Question	Primary care	Acute
4.2 Is there evidence of the treatment plan having been given to the patient (e.g. by patient letter, in discharge summary, through information leaflets)	57% (107/188)	25% (107/424)

Table 45:

Question	Primary care	Acute
4.3 Are plans for follow up and review clearly documented?	61% (114/188)	41% (174/424)

Table 46:

Question	Primary care	Acute
4.4 Where relevant, have details of the treatment plan been shared with the patients' carer/relative?	26% (49/188)	31% (133/424)

Table 47:

Question	Primary care	Acute
4.5 Has the patient been provided with information on causes and treatment of UI?	41% (78/188)	22% (93/424)

Table 48:

Question	Primary care	Acute
4.6 Has the patient been provided with advice on how to cope with UI?	40% (76/188)	21% (88/424)

Table 49:

Question	Primary care	Acute
4.7 What did this advice include?		
4.7a Advice and information on continence products	57% (43/76)	72% (63/88)
4.7b Advice on skin care	41% (31/76)	48% (42/88)
4.7c Advice relating to preservation of dignity	51% (39/76)	63% (55/88)
4.7d Advice relating to preservation of independence	54% (41/76)	60% (53/88)
4.7e Contact details for relevant support groups and/or helplines	21% (16/76)	35% (31/88)
4.7f Periodic review of symptoms	87% (66/76)	81% (71/88)
4.7g Psychological and emotional support	51% (39/76)	72% (63/88)

Faecal incontinence clinical audit – case note review

Audit information

There were 45 cases from 17 primary care sites (median 1, IQR 1-3), 155 from 45 acute secondary care sites (median 3 IQR 2-5) and 2 from 2 mental health sites. For this report these 2 mental health cases have been combined with acute care, to form a total 157 'acute' cases.

47% (21/45) of primary care and 42% (66/157) of acute care patients were male.
51% (23/45) of primary care and 88% (138/157) of acute care patients were aged 65 and over.

Clinical setting for primary care:

- Hospital medical ward (9%, 4)
- Hospital surgical ward (18%, 8)
- Hospital elderly care ward (16%, 7)
- Hospital outpatient clinic (4%, 2)
- Community clinic (42%, 19)
- Care home (0%, 0)
- GP (2%, 1)
- Other (9%, 4)

Others: own home (4)

Clinical setting for acute care:

- Hospital medical ward (37%, 58)
- Hospital surgical ward (<1%, 1)
- Hospital elderly care ward (50%, 78)
- Hospital outpatient clinic (<1%, 1)
- Community clinic (5%, 8)
- Care home (0%, 0)
- GP (0%, 0)
- Other (7%, 11)

Others: Hospital mental health older adults (5), stroke rehab unit (1), stroke rehab ward (1), Graham ward (3), not stated (1)

Notes audited for primary care:

- Hospital notes (24%, 11)
- GP notes (0%, 0)
- Continence specialist records (76%, 34)
- Care home care plan (0%, 0)

Notes audited for acute care:

- Hospital notes (94%, 147)
- GP notes (0%, 0)
- Continence specialist records (6%, 00)
- Care home care plan (0%, 0)

How was urinary incontinence identified for this audit case/person in primary care:

- Routine screening by a provider (42%, 19)
- Patient sought help for the problem (40%, 18)
- Was only identified through case-finding for this audit (4%, 2)
- Other (13%, 6)
- Not known (0%, 0)

Others: Referred by Gp (1), taken off clinic rota (2), carer sought help (1), care staff from an agency (1), relatives/staff on ward (1)

How was urinary incontinence identified for this audit case/person in acute care:

- Routine screening by a provider (54%, 85)
- Patient sought help for the problem (10%, 15)
- Was only identified through case-finding for this audit (27%, 43)
- Other (8%, 13)
- Not known (<1%, 1)

Others: Carer referral (1), developed in hospital (1),During continence assess of urinary incontinence (1), Hospital informed by nursing home on admission (1), identified on ward (1), Identified on ward by staff (1), Not recorded (1), Nothing recorded (1), on admission to hospital (1), Post-surgery complication (1), referral (1), starfg (1), Whilst in, contracted C. Diff (1)..

1. Symptoms

Table 50:

Question	Primary care	Acute
1.1 Are the patients faecal incontinence symptoms documented?	96% (43/45)	77% (121/157)
1.2 Do the symptoms of faecal incontinence include:		
1.2a Duration of symptoms?	74% (32/43) Yes (symptom documented) 12% (5/43) No (symptom documented as not being present) 14% (6/43) No documentation about this symptom	68% (82/121) Yes (symptom documented) 14% (17/121) No (symptom documented as not being present) 18% (22/121) No documentation about this symptom
1.2b Frequency of FI?	74% (29/39) 4 Not documented	78% (78/100) 21 Not documented
1.2c Urgency?	61% (23/38) 5 Not documented	29% (25/87) 34 Not documented
1.2d Passive leakage?	62% (24/39) 4 Not documented	39% (38/98) 23 Not documented
1.2e Constipation symptoms?	63% (27/43) 0 Not documented	61% (67/109) 12 Not documented
1.2f Co-existing urinary incontinence?	69% (29/42) 1 Not documented	70% (80/115) 6 Not documented

Table 51:

Question	Primary care	Acute
1.3 Has a stool diary or bowel chart been used to record frequency of incontinence?	69% (31/45)	74% (116/157)
1.3a Who completed the stool diary or bowel chart?		
Patient completed	61% (19/31)	6% (7/116)
Provider completed	39% (12/31)	94% (109/116)

Table 52:

Question	Primary care	Acute
1.4 If the patient has urinary incontinence, are bladder symptoms documented (e.g. urinary urgency, stress leakage, nocturia)?	93% (28/30) 15 Patient does not have urinary incontinence	49% (59/120) 37 Patient does not have urinary incontinence

2. Medication / Assessment / Investigations

Table 53:

Question	Primary care	Acute
2.1 Have the patients' medications been reviewed to assess whether they may be worsening faecal incontinence?	80% (36/45)	52% (81/157)
2.1a Have any such medications been altered as a result of this review?	61% (22/36)	53% (43/81)

Table 54:

Question	Primary care	Acute
2.2 Have medical conditions that may be relevant to faecal incontinence been reviewed (e.g. diabetes, heart failure, neurological conditions)	94% (30/32) 13 Patient does not have any coexisting medical conditions	69% (92/134) 23 Patient does not have any coexisting medical conditions
2.2a Have any such medical conditions been optimised as a result of this review?	70% (21/30)	66% (61/92)

Table 55:

Question	Primary care	Acute
2.3 Has the patient's functional ability been assessed?	89% (40/45)	85% (134/157)

Table 56:

Question	Primary care	Acute
2.4 Has the patient's cognition been assessed?	82% (37/45)	80% (126/157)

Table 57:

Question	Primary care	Acute
2.5 Has the impact of incontinence on quality of life been assessed?	69% (31/45)	20% (32/157)
2.5a Has Quality of Life been recorded by standard assessment tool?	42% (13/31)	47% (15/32)

Table 58:

Question	Primary care	Acute
2.6 Has an assessment been performed focusing on finding the cause(s) of faecal incontinence?	84% (38/45)	58% (91/157)
2.6a IF YES: Who did this assessment?		
GP	0% (0/38)	2% (2/91)
Practice nurse	0% (0/38)	0% (0/91)
District nurse	3% (1/38)	1% (1/91)
Continence specialist	82% (31/38)	11% (10/91)
Hospital ward doctor	11% (4/38)	65% (59/91)
Hospital ward nurse	3% (1/38)	12% (11/91)
Hospital continence specialist (includes surgeon)	3% (1/38)	9% (8/91)
Care home nurse	0% (0/38)	0% (0/91)

Table 59:

Question	Primary care	Acute
2.7 At this assessment what was performed:		
2.7a Examination of abdomen for palpable mass bladder retention?	32% (12/38)	85% (77/91)
2.7b Examination of perineum and anus?	42% (16/38)	53% (48/91)
2.7c Digital assessment of sphincter tone?	42% (16/38)	44% (40/91)
2.7d Rectal examination?	50% (19/38)	59% (54/91)

Investigations

Table 60:

Question	Primary care	Acute
2.8 What investigations were performed?		
2.8a Stool culture for loose stool	24% (11/45)	39% (61/157)
2.8b Abdominal x-ray	11% (5/45)	27% (43/157)
2.8c Sigmoidoscopy	7% (3/45)	3% (5/157)
2.8d Colonoscopy	11% (5/45)	5% (8/157)
2.8e Abdominal CT or ultrasound	4% (2/45)	10% (16/157)
2.8f CT enema (virtual colonoscopy)	4% (2/45)	1% (2/157)
2.8g Endoanal ultrasound	2% (1/45)	1% (2/157)
2.8h Anorectal physiology	0% (0/45)	3% (4/157)

Table 61:

Question	Primary care	Acute
2.9 Is the type or cause(s) of faecal incontinence documented in the notes?	64% (29/45)	52% (82/157)
IF YES: Are the cause(s) documented as:		
2.9a Overflow from constipation	34% (10/29)	43% (35/82)
2.9b Diarrhoea	24% (7/29)	32% (26/82)
2.9c Medication side-effect	24% (7/29)	12% (10/82)
2.9d Anal sphincter damage	34% (10/29)	5% (4/82)
2.9e Anal sphincter damage obstetric-related	14% (4/29)	4% (3/82)
2.9f Other anorectal condition	24% (7/29)	15% (12/82)
2.9g Neuropathic bowel (diabetes, neurological conditions etc.)	34% (10/29)	15% (12/82)
2.9h Functional / cognitive	31% (9/29)	44% (36/82)

3. Treatment

Table 62:

Question	Primary care	Acute
3.1 Does the patient have a treatment plan?	84% (38/45)	62% (97/157)
3.2 Does the **treatment plan** include;		
3.2a Further investigations	26% (10/38)	32% (31/97)
3.2b Referrals to another specialist or service	42% (16/38)	29% (28/97)
3.2c Starting treatment	79% (30/38)	53% (51/97)
3.2d Organised follow up	87% (33/38)	46% (45/97)

Table 63:

Question	Primary care	Acute
3.3 Does documented treatment include;		
3.3a Pelvic floor / anal sphincter exercises?	58% (22/38)	6% (6/97)
3.3b Bowel retraining?	47% (18/38)	11% (11/97)
3.3c Fluid and dietary advice?	89% (34/38)	54% (52/97)
3.3d Specific treatment for diarrhoea (e.g. antibiotics, treatment for inflammatory bowel disease, removal of polyp/tumour)	3% (1/38)	23% (22/97)
3.3e Anti-diarrhoeal medication	21% (8/38)	12% (12/97)
3.3f Laxatives	50% (19/38)	47% (46/97)
3.3g Enemas or suppositories	21% (8/38)	27% (26/97)
3.3h Biofeedback	0% (0/38)	1% (1/97)
3.3i Anorectal surgery	3% (1/38)	10% (10/97)
3.3j Containment – pads	39% (15/38)	70% (68/97)
3.3k Containment – bowel management	32% (12/38)	11% (11/97)

Table 64:

Question	Primary care	Acute
3.4 Has long-term faecal Incontinence management /advice been given to the patient?	64% (29/45)	18% (28/157)
What did this advice include:		
3.5a Advice and information on continence products	62% (18/29)	75% (21/28)
3.5b Advice on skin care	62% (18/29)	75% (21/28)
3.5c Advice relating to preservation of dignity	83% (24/29)	64% (18/28)
3.5d Advice relating to preservation of independence	83% (24/29)	61% (17/28)
3.5e Contact details for relevant support groups and or helplines	45% (13/29)	18% (5/28)
3.5f Periodic review of symptoms	97% (28/29)	79% (22/28)
3.5g Psychological and emotional support	59% (17/29)	46% (13/28)

Table 65:

Question	Primary care	Acute
3.6a Does the patient have any of the following consequences of faecal Incontinence:		
3.6b Urinary tract infection or urosepsis?	9% (4/45)	22% (34/157)
3.6c Pressure ulcers?	2% (1/45)	12% (19/157)

4. Care Plan / communication

Table 66:

Question	Primary care	Acute
4.1 Has the patients own goals/decisions for treatment and care been documented?	60% (27/45)	25% (40/157)

Table 67:

Question	Primary care	Acute
4.2 Is there evidence of the treatment plan having been given to the patient (e.g. by patient letter, in discharge summary, through information leaflets)	67% (30/45)	17% (27/157)

Table 68:

Question	Primary care	Acute
4.3 Are plans for follow up and review clearly documented?	69% (31/45)	35% (55/157)

Table 69:

Question	Primary care	Acute
4.4 Where relevant, have details of the treatment plan been shared with the patients' carer/relative?	36% (16/45)	27% (43/157)

Table 70:

Question	Primary care	Acute
4.5 Has the patient been provided with written advice and information on causes and treatment of faecal incontinence?	49% (22/45)	10% (15/157)

Organisational audit result for care homes

There were 8 Pilot care homes, with data submitted between 1 November 2011 and 24 December 2011

1. Policies and Commissioning

Table 71:

Question	Care home
1.1 Does the care home have a written policy for the management of continence?	8/8
Does this written policy include:	
1.1a Training for staff in continence care?	6/8
1.1b Assessment and treatment of incontinence?	7/8
1.1c A means for regular audit of continence care?	5/8

Table 72:

Question	Care home
1.2 Does your care home have a contract for resident placement with the NHS or Local Authority, which includes a quality indicator relating to;	
1.2a Catheters	4 Yes, 2 No, 2 NK
1.2b Urinary Incontinence	4 Yes, 2 No, 2 NK
1.2c Faecal incontinence	4 Yes, 2 No, 2 NK

Table 73:

Question	Care home
1.3 Are there any financial penalties or additional payments linked to the achievement of the continence quality indicators in 1.2 questions above?	5 No, 3 NK

Table 74:

Question	Care home
1.4 Do you have any written guidance or protocols for staff on:	
1.4a Care of catheters	7/8
1.4b Assessment, management and/or treatment of urinary incontinence	7/8
1.4c Assessment, management and/or treatment of faecal incontinence	7/8
1.4d Management and treatment of urinary tract infections?	6/8

Table 75:

Question	Care home
1.5 How long do your residents wait from referral to being seen for an assessment visit by the Continence Nurse Specialist?	
1-2 weeks	5
2-4 weeks	2
4-8 weeks	-

8-18 weeks	1
Greater than 18 weeks	-

Table 76:

Question	Care home
1.6 Care homes providing personal care only: How long do your residents have to wait for a continence assessment visit by a district nurse?	
Within 3 days	2
Within 1 week	2
Within 2 weeks	1
Longer than 2 weeks	1
Do not provide personal care	2

Table 77:

Question	Care home
1.7 When you request that a GP sees a resident for 'continence related problems', how long do your residents have to wait?	
Within 3 days	6
Within 1 week	2
Within 2 weeks	-
Longer than 2 weeks	-

2. Clinical Protocols

Table 78:

Question	Care home
2.1 Do you ask screening question(s) relating to bladder and bowel problems as part of the pre admission assessment?	7/8

Table 79:

Question	Care home
2.2 Do you ask screening question[s] relating to bladder and bowel problems as part of the assessment on admission?	6/8

Table 80:

Question	Care home
2.3 Is there a protocol or pathway that is initiated when a patient responds to the screening question(s) that they have a bladder or bowel problem?	4 Yes, 3 No, 1 NK

Table 81:

Question	Care home
2.4 Is there a written protocol for providing an initial assessment for all people who indicate that they have problems with urinary and/or faecal continence?	4/8

Table 82:

Question	Care home
2.5 Is there a lead link person/ nurse for continence in your care home?	5 Yes, 1 No, 2 NK

3. Training

Table 83:

Question	Care home
3.1 Is there a structured programme of staff training on:	
3.1a Promoting and managing continence?	3/8
3.1b Treatment of continence?	3/8

Table 84:

Question	Care home
3.2 Does the staff training target:	
3.2a Care workers	7/8
3.2b Nurses	4/8
3.2c Continence link nurses/ care workers	3/8

Table 85:

Question	Care home
3.3 Is the staff training :	
One off (such as at induction/starting at care home)	5
Rolling programme(annual refresher or different sessions over a time period)	3

Table 86:

Question	Care home
3.4 Nursing homes only: Do you provide training for your nurses in how to undertake continence assessments?	3 Yes, 3 No, 2 Nursing Home

4. Privacy and Dignity

Table 87:

Question	Care home
4.1 Do all of your environments provide:	
4.1a Privacy around the toilet area	8/8
4.1b Easily accessible and identifiable toilet facilities	8/8
4.1c Appropriate aids to toileting (frames /rails etc)	8/8
4.1d Privacy when staff speak to residents in confidence	8/8
4.1e Hand washing after toileting	8/8
	8/8

5. Audit

Table 88:

Question	Care home
5.1 Is the bladder or bowel care delivered in the care home regularly audited?	3/8

Table 89:

Question	Care home
5.2 What aspect of the care is audited:	
5.2a Use of catheters and their management?	3/3
5.2b Assessment, management and/or treatment of urinary incontinence?	3/3
5.2c Assessment, management and/or treatment of faecal incontinence?	3/3
5.2d Privacy and dignity in managing continence?	3/3
5.2e Use of continence management plans and toileting regimes?	3/3

6. Continence products

Table 90:

Question	Care home
6.1 What is the daily limit on the number of continence products/ pads provided for each of your residents by the:	
6.1a NHS	Three (n=1), Four (n=6), Five (n=1)
6.1b Local Council	Zero (n=3), Four (n=4), Five (n=1)

Table 91:

Question	Care home
6.2 If there is a limit can the care home purchase for their residents:	
6.2a All products / pads	4/8
6.2b Top up products / pads	5/8

Table 92:

Question	Care home
6.3 Are products supplied on the basis of clinical and resident need rather than cost?	6/8

Table 93:

Question	Care home
6.4 Do residents have access (on the NHS) to the product of their choice (such as washable briefs)?	3/8

Table 94:

Question	Care home
6.5 Are you able to request an assessment or review for additional products if this is required by the resident?	8/8

Table 95:

Question	Care home
6.6 Does your local primary care trust (PCT) have a protocol stating that a continence assessment should be carried out before products are provided to residents?	8/8

7. Patient carer information and support

Table 96:

Question	Care home
7.1 Does the care home/PCT/community continence provide information about bladder and bowel care to residents and families?	5/8

Urinary incontinence clinical audit – resident care record review

There were 68 pilot cases submitted from 9 pilot care homes, three with 10 cases, two with 9 cases, one with 7, one with 5 and two with 4 cases. Cases submitted 3 October 2011 to 3 January 2012, median 6 December 2011, Inter Quartile Range 2 November 2011 to 22 December 2011. 16 Males, 52 Females, all aged 65 and over. Note that the free-text comments were from one site only and relating to a total of 4 residents

1. Symptoms

Table 97:

Question	Care home
1.1 How was this resident identified as being incontinent of urine?	
During pre- admission assessment	33
During admission assessment	2
Identified by care home following admission	30
Resident sought help for the problem?	3
Was only just identified through case-finding for this audit?	-

Table 98:

Question	Care home
1.2 Has the resident's continence symptoms been documented in the care plan?	68/68

2. Management / Assessment / Investigations

Table 99:

Question	Care home
2.1 Has the resident or the care home been asked to complete a bladder diary by the GP, District Nurse or Continence Nurse Specialist?	41/68

Table 100:

Question	Care home
2.2 Have the residents' medications been reviewed by the GP; District Nurse; continence nurse specialist or Pharmacist, to assess whether they may be worsening urinary incontinence?	45/64 4 not taking medication
2.2a Have any medications been altered as a result of this review?	5/45

Table 101:

Question	Care home
2.3 Have medical conditions that may be relevant to urinary incontinence been reviewed by the GP; District Nurse or continence nurse specialist (e.g. diabetes, heart failure, or stroke)	35/43 25 resident has none of these conditions
2.3a Have any medical conditions been improved / optimised as a result of this review?	6/35

Table 102:

Question	Care home
2.4 Has the resident's cognition/ awareness been assessed?	59/68

Table 103:

Question	Care home
2.5 Has the resident's physical function and ability to self-toilet been assessed?	67/68

Table 104:

Question	Care home
2.6 Has the impact of incontinence on the resident's quality of life been assessed? e.g. social isolation, low self-esteem, missing activities in the care home, missing trips out)	54/68

Investigations

Table 105:

Question	Care home
2.7 Has a urine dip stick been done?	63/68

Table 106:

Question	Care home
2.7a In care homes providing personal care only: Who has done the urine dip stick?	
District nurse	12/63
Continence Nurse Adviser	13/63
Other	38/63

Table 107:

Question	Care home
2.8 Has an assessment been performed to find the cause of the urinary incontinence?	52/68

Table 108:

Question	Care home
2.8a Who did this assessment?	
Nurse in care home	11/52
District Nurse	14/52
GP	4/52
Continence Nurse Specialist	17/52
Hospital	6/52

Table 109:

Question	Care home
2.9 Is there evidence in records of any of the following **routine tests** being carried out **in the care home**:	
2.9a Mid stream specimen of urine?	38/68
2.9b Catheter specimen of urine?	12/23 45 No catheter

3. Treatment

Table 110:

Question	Care home
3.1 Has the GP, District Nurse, Continence Advisor or hospital identified/recorded the type or cause of the urinary incontinence?	50/68

Table 111:

Question	Care home
3.2 What is the type/cause:	
3.2a Stress urinary incontinence?	9/50
3.2b Urge urinary incontinence?	9/50
3.2c Enlarged prostate?	6/50
3.2d Neuropathic bladder?	4/50
3.2e Urinary tract infection?	9/50
3.2f Medication side-effect?	0/50
3.2g Constipation (causing retention of urine)?	1/50
3.2h Functional or cognitive deterioration?	42/50

Table 112:

Question	Care home
3.3 Is the resident having any of the following treatment:	
3.3a Pelvic floor exercises?	3/68
3.3b Bladder retraining?	0/68
3.3c Fluid advice?	42/68
Medicines	
3.3d Bladder medication?	6/68
3.3e Prostate medication?	4/68
Surgery	
3.3f Prostatic surgery?	1/68
3.3g Urogynaecological surgery?	1/68
Catheter	
3.3h Intermittent catheterisation?	0/68
3.3i In-dwelling catheterisation?	9/68
Product use	
3.3j Containment – pads?	61/68
3.3k Containment sheath, other products?	1/68

Table 113:

Question	Care home
3.4 Is the resident catheterised?	9/68

Table 114:

Question	Care home
3.5 Is the reason for catheterisation clearly recorded?	8/9

Table 115:

Question	Care home
3.6 Is this reason because of:	
3.6a Sudden inability to pass any urine [acute retention]?	1/8
3.6b Long standing inability to pass urine [chronic retention with kidney problems]?	2/8
3.6c Serious accident/ trauma/ or following surgery?	0/8
3.6d Deteriorating health due to illness?	6/8
3.6e Severe pressure sores or a wound?	0/8
3.6f Was admitted with a catheter in place	4/8

Table 116:

Question	Care home
3.7 Is there a documented plan for removal of the catheter?	2/9

Table 117:

Question	Care home
3.8 Does the resident have any consequences of urinary incontinence such as pressure sores?	2/68

4. Treatment and care plans

Table 118:

Question	Care home
4.1 Has a treatment plan been given to the resident (e.g. by letter, or in the hospital discharge summary, by the GP, District nurse, or Continence Nurse Specialist)	24/68
4.1a Is there evidence that their treatment plan is included in the care plan?	24/24
4.1b Are plans for follow up or review clearly documented in the treatment plan?	23/24
4.1c Is the resident's choice or decisions recorded in the treatment plan?	7/9 15 Not able to decide on own goals

Table 119:

Question	Care home
4.2 Is the resident's choice or decisions recorded in the care plan?	36/36 32 Not able to decide on own goals

Table 120:

Question	Care home
4.3 Does the care plan state how to:	
4.3a Maintain privacy whilst providing continence care?	67/68
4.3b Provide continence products that meet the resident's need?	68/68
4.3c Provide skin care?	66/68
4.3d Check for signs of urinary infection?	67/68
4.3e Recognise signs or provide advice of when the resident likes to go to the toilet?	64/68
4.3f Ensure the resident has drunk and eaten enough to help with continence?	67/68

Table 121:

Question	Care home
4.4 Is there a follow up or review date clearly documented in the care plan?	64/68
4.4a Has the care plan been reviewed on this date?	43/43 21 No, but review date in the future

Information

Table 122:

Question	Care home
4.5 Has the resident and/or their family been provided with written advice and information about urinary incontinence such as causes and treatment, how to cope, caring for skin, access to support groups, and helpline numbers	14/45 23 Not applicable due to lack of capacity

Faecal incontinence clinical audit – resident care record review

There were 16 pilot cases submitted from 6 pilot care homes, one with 6 cases, one with 5 cases, one with 2, and three with 1 case. Cases submitted 8 November 2011 to 28 December 2011.5 Males, 11 Females, 15 aged 65 and over & 1 aged 18-65. Note that the free-text comments were from one site only and relating to one resident

1. Symptoms

Table 123:

Question	Care home
1.1 How was this resident identified as being incontinent of their bowels (faecal incontinence)?	
During pre- admission assessment	9
During admission assessment	-
Identified by care home following admission	7
Resident sought help for the problem?	-
Was only just identified through case-finding for this audit?	-

Table 124:

Question	Care home
1.2 Has the resident's bowel symptoms been recorded in the care plan?	15/16
1.2a Is the resident also incontinent of urine?	16/16

2. Medication / Assessment / Investigations

Table 125:

Question	Care home
2.1 Has the GP, District nurse, or continence nurse specialist asked you to use a stool diary or chart to record frequency of incontinence for this resident?	9/16

Table 126:

Question	Care home
2.2 Have the resident's medications been reviewed by the GP, District Nurse, Continence specialist nurse or pharmacist, to assess whether they may be worsening faecal incontinence?	14/16
2.2a Have any medications been altered as a result of this review?	6/14

Table 127:

Question	Care home
2.3 Have medical conditions that may be relevant to faecal incontinence been reviewed by the GP, District Nurse, Continence Nurse Specialist (e.g. diabetes, heart failure, or stroke)	13/15 1 Resident has none of these
2.3a Have any medical conditions been improved/optimised as a result of this review?	1/11 2 Resident has none of these

Table 128:

Question	Care home
2.4 Has the resident's cognition/ awareness been assessed?	15/16

Table 129:

Question	Care home
2.5 Has the resident's physical function and ability to self-toilet been assessed?	16/16

Table 130:

Question	Care home
2.6 Has the impact of incontinence on the resident's quality of life been assessed? e.g. social isolation, low self-esteem, missing activities in the care home, missing trips out)	15/16

Table 131:

Question	Care home
2.7 Is there documented evidence of rectal examination carried out by a nurse in the care home, or district nurse, continence nurse specialist or GP?	6/16

Table 132:

Question	Care home
2.8 Has an examination and assessment been performed to find the cause of faecal incontinence?	11/16

Table 133:

Question	Care home
2.9 Who did this assessment?	
Nurse in care home	6
District Nurse	1
GP	3
Continence Nurse Specialist	1
Hospital	5

3. Treatment

Table 134:

Question	Care home
3.1 Did the resident have a treatment plan provided by the GP, district nurse, continence nurse specialist or hospital?	11/16

Table 135:

Question	Care home
3.2 Has the GP, district nurse, continence nurse specialist or hospital identified/recorded the type or cause of the resident's faecal incontinence?	10/16

Table 136:

Question	Care home
3.3 Is the type/cause of faecal incontinence recorded as:	
3.3a Overflow from constipation	3/16
3.3b Diarrhoea	0/16
3.3bi If diarrhoea, has the cause of diarrhoea been recorded?	-
3.3c Medication side-effect	4/16
3.3d Anorectal condition (e.g. sphincter damage, anorectal surgery, anorectal cancer, rectal prolapse)	2/16
3.3e Neurological conditions (e.g. stroke, multiple sclerosis, Parkinson's Disease)	5/16
3.3f Functional / cognitive deterioration	14/16

Table 137:

Question	Care home
3.4 Does the treatment for the resident include:	
3.4a Pelvic floor / anal sphincter exercises?	0/16
3.4b Bowel retraining?	0/16
3.4c Fluid and dietary advice?	10/16
Medicines	
3.4d Specific treatment for diarrhoea (eg antibiotics, treatment for Irritable Bowel Disease)?	1/16
3.4e Antidiarrhoeal medicines or tablets?	1/16
3.4f Laxatives?	13/16
3.4g Enemas or suppositories?	3/16
Surgery	
3.4h Anorectal surgery?	0/16
Product use	
3.4i Containment – pads?	14/16
3.4j Containment – bowel management?	5/16

Table 138:

Question	Care home
3.5 Does the resident currently have any consequences of faecal incontinence such as pressure sores?	1/16

4. Care plans / Communication

Table 139:

Question	Care home
4.1 Has a treatment plan been given to the resident (e.g. by letter, or in the hospital discharge summary, by the GP, District nurse, or Continence Nurse Specialist)	5/16
4.1a Is there evidence that their treatment plan is included in the care plan?	15/16
4.1b Are plans for follow up or review clearly documented in the treatment plan?	15/16
4.1c Is the resident's choice or decisions recorded in the treatment plan?	3/4 12 Not able to decide on own goals

Table 140:

Question	Care home
4.2 Is the resident's choice or decisions recorded in the care plan?	3/16

Table 141:

Question	Care home
4.3 Does the care plan state how to:	
4.3a Maintain privacy whilst providing continence care?	16/16
4.3b Provide continence products that meet the resident's need?	16/16
4.3c Provide skin care?	16/16
4.3d Provide psychological and emotional support?	12/16
4.3e Recognise signs or provide advice of when the resident likes to go to the toilet?	14/16
4.3f Ensure the resident has drunk and eaten enough to help with continence?	16/16
4.3g Preserve the resident's independence	15/16

Table 142:

Question	Care home
4.4 Is there a follow up or review date clearly documented in the care plan?	9/16
4.4a Has the care plan been reviewed on this date?	7/8 8 No, but review date in the future

Table 143:

Question	Care home
4.5 Has the resident and/or their family been provided with written advice and information about faecal incontinence such as causes and treatment, how to cope, caring for skin, access to support groups, and helpline numbers?	1/3 13 Not applicable due to lack of capacity

Appendix 1

National Audit of Continence Care Steering Group

Title	Forename	Surname	Representing
Dr	Danielle	Harari	Clinical Effectiveness and Evaluation Unit, Royal College of Physicians (Associate director and chair)& British Geriatric Society
Dr	Kevin	Stewart	Clinical Effectiveness and Evaluation Unit, Royal College of Physicians (Director)
Mrs	Janet	Husk	Clinical Effectiveness and Evaluation Unit, Royal College of Physicians (Programme manager)
Mr	Jose	Lourtie	Clinical Effectiveness and Evaluation Unit, Royal College of Physicians (Project coordinator)
Ms	Rhona	Buckingham	Clinical Effectiveness and Evaluation Unit, Royal College of Physicians (CEEU Manager)
Dr	Adrian	Wagg	Professor of Healthy Ageing, University of Alberta, Edmonton
Dr	Karen	Ward	British Society of Urogynaecology
Dr	Imran	Rafi	Royal College of General Practitioners
Mrs	Gaye	Kyle	Association for Continence Advice / Bowel care expertise
Ms	Amanda	Cheesley	Royal College of Nursing
Mr	Stephen	Miles	Royal College of Nursing
Dr	Doreen	McClurg	Physiotherapist – ACPWH
Ms	Debbie	Yarde	Chair – Association of Continence Advice
Ms	Ginny	Storey	Head of Care Governance & Regulation – Anchor Care Homes
Ms	Julie	Vickerman	PromoCon & Disabled Living Manchester
Ms	Mandy	Wells	Head of Bladder & Bowel Devon
Mr	Phil	Assassa	Bladder and Bowel Foundation
Dr	Ronald	Fernandes	MS Society
Dr	Margit	Physant	Age UK
Ms	Lavinia	Fernandes	Parkinson's UK
Mr	Ian	Ireland	Director, IAI consultancy – Care Home Sector

Appendix 2

National Audit of Continence Care 2011
Pilot Organisational Audit Proforma
(please complete all questions)

Your Site Code ☐

Instructions for completion:
1. Please use a ball-point 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*. We will need to talk about what will be in the 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

0.1	Cycle no:	
1.	**Policies and Commissioning**	
1.1	Do you have a **written policy** for the management of continence (in your GP practice/ hospital /care home)?	○Yes / ○No **If no go to 1.3**
1.2	Does this written policy include directions on:	
1.2a	• Training for staff in delivery of continence care	○Yes / ○No
1.2b	• Assessment and treatment of incontinence	○Yes / ○No
1.2c	• Shared and agreed pathways of care (across disciplines and care boundaries)	○Yes / ○No
1.2d	• Regular audit of continence services	○Yes / ○No
1.3	Do you have a quality indicator, CQUIN or other relating to:	
1.3a	Catheters and/or Catheter associated urinary tract infection (CAUTI)	○Yes / ○No
1.3b	Urinary Incontinence	○Yes / ○No
1.3c	Faecal incontinence	○Yes / ○No
1.4	What organisation is responsible for commissioning continence services?	○GP consortia ○PCT ○Foundation Trust ○Private industry (for care homes) ○Don't know **If don't know go to Q1.5.**
1.4a	Does this 'organisation' have a specific commissioning programme for continence?	○yes / ○No / ○Don't know
1.5	Is there a lead for continence care or services in your organisation?	○yes / ○No / ○Don't know
1.6	How many continence nurse specialists (CNS)/ specialist continence practitioners are currently employed in your organisation?	Number is: FTE is ☐ ○Don't know. **If don't know go to q2.1**
1.6a	From the date of completion of this audit - During the last 12 months has the number of FTE continence nurse specialists /specialist continence practitioners:	○Fallen ○Increased ○Stayed the same ○Don't know
2	**CLINICAL PROTOCOLS**	

2.1	Is your practice to always ask a screening question(s) relating to bladder and bowel problems as part of the initial patient/client assessment?	○Yes / ○No **If yes can answer all of Q2.2 and Q2.3.** **If no go to Q2.4**
2.1a	**IF YES** – What is this screening question? (FREE TXT)	**Free text 200 characters**
2.2	**IF YES** Is the screening question:	
2.2a	Part of routine nursing assessment?	○Yes / ○No
2.2b	Part of routine doctor assessment?	○Yes / ○No
2.2c	Asked on admission?	○Yes / ○No
2.2d	Asked as part of assessment for pads?	○Yes / ○No
2.3	Is there a protocol or pathway that is initiated when a patient responds to the screening question(s) that they have a bladder or bowel problem?	○Yes / ○No / ○Don't know
2.4	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
3.	**Investigations / treatment / facilities**	
3.1	Does your local service have investigation and treatment facilities?	○Yes / ○No **If no go to Q4.1**
3.2	Do these investigation and treatment facilities include:	**Select all that apply**
3.2a	• Urodynamics?	○Yes / ○No
3.2b	• Urinary or gastrointestinal tract imaging?	○Yes / ○No
3.2c	• Anorectal physiology?	○Yes / ○No
4	**Training**	
4.1	Is there a structured **programme of staff training** on promoting continence?	○Yes / ○No / ○Don't know **If No or Don't know go to Q4.3**
4.2	Does the staff training target:	**Select all that apply**
4.2a	• Doctors	○Yes / ○No
4.2b	• Nurses	○Yes / ○No
4.2c	• Multidisciplinary group (other qualified)	○Yes / ○No
4.2d	• Non qualified staff	○Yes / ○No
4.3	Is the staff training:	**Select one**
4.3a	• One off (e.g at induction)	○
4.3b	• Rolling programme	○
4.4	Does the staff training create Continence link workers?	○Yes / ○No

5	**Privacy and Dignity**	
5.1	Do the environments listed always allow for intimate conversations with/examinations/care of patients:	
5.1a	• Bed area	○Yes / ○No / ○Don't know
5.1b	• Toilets	○Yes / ○No / ○Don't know
5.1c	• Bathrooms	○Yes / ○No / ○Don't know
5.1d	• Outpatient clinics	○Yes / ○No / ○Don't know
5.2	Are patients/clients who are bed bound and need to use the toilet in the bed or a commode always offered hand washing after toileting?	○Yes / ○No / ○Don't know
6	**Audit**	
6.1	Is there a regular audit of bladder or bowel care?	○Yes / ○No
6.2	What aspect of the bladder or bowel care is audited:	
6.2a	• Catheter use?	○Yes / ○No
6.2b	• Assessment and treatment of urinary incontinence?	○Yes / ○No
6.2c	• Assessment and treatment of faecal incontinence?	○Yes / ○No
6.2d	• Privacy and dignity?	○Yes / ○No
6.2e	• Patient experience?	○Yes / ○No
6.3	Does the continence service have a user group?	○Yes / ○No / Don't know
6.4	Does the continence service user group:	
6.4a	• Provide support for other users and or carers?	○Yes / ○No / ○Don't know
6.4b	• Inform service delivery?	○Yes / ○No / ○Don't know
6.4c	• Review patient educational materials?	○Yes / ○No / ○Don't know
7	**Continence Products**	
7.1	Is there a daily limit for continence products?	○Yes / ○No
7.2	Are products supplied on the basis of clinical and patient need rather than cost?	○Yes / ○No
7.3	Is a continence assessment and care offered at the point of providing people with pads for the first time?	○Yes / ○No
7.4	Do patients have access (on the NHS) to the product of their choice such as washable briefs?	○Yes / ○No
8	**Patient Carer Information and Support**	
8.1	Is evidence-based information about bladder and bowel care freely available to patients and carers?	○Yes / ○No

National Audit of Continence Care 2011

Pilot Bladder Audit Proforma

(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*.

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

	DEMOGRPHIC INFORMATION	Response
A.	Patient numbers	Automatically generated by webtool
B.	Audit date:	Date field
B i	Cycle number	2 digit number
C.	Bladder Proforma	
D.	Patient age	○18-65 / ○65+
E.	Patient gender	○Male / ○Female
F.	Clinical setting	○Hospital medical ward ○Hospital surgical ward ○Hospital elderly care ward ○Hospital outpatient clinic ○GP surgery ○Community clinic ○Care home
G.	Notes audited	○Hospital notes ○GP notes ○Continence specialist records ○Care home care plan
H.	How was urinary incontinence identified for this audit case/person?	○Routine screening by a provider ○Patient sought help for the problem ○Was only identified through case-finding for this audit ○Other ☐ ○Not Known

1	**Symptoms**	
1.1	Has the patients urinary symptoms been recorded in the notes?	○Yes /○No
1.2	Have the following symptoms been asked about:	
1.2a	• Urinary frequency?	○Yes /○No
1.2b	• Urgency?	○Yes /○No
1.2c	• Stress?	○Yes /○No
1.2d	• Voiding difficulties?	○Yes /○No
1.2e	• Nocturia?	○Yes /○No
1.2f	• Pain on urination?	○Yes /○No
1.2g	• Constipation?	○Yes /○No
1.2h	• Faecal incontinence?	○Yes /○No

1.3	Has the patient completed a bladder diary? (Men and women)	○Yes /○No
1.4	Has the patient completed a three day bladder diary? **WOMEN ONLY**	○Yes /○No /○ patient is male

2	**Management / Assessment / Investigations**	
2.1	Have the patients' medications been reviewed to assess whether they may be worsening urinary incontinence?	○Yes /○No **If no go to 2.2**
2.1a	Have any such medications been altered as a result of this review?	○Yes /○No
2.2	Have medical conditions that may be relevant to urinary incontinence been reviewed (e.g. diabetes, heart failure, neurological conditions)	○Yes /○No /○ Patient does not have any coexisting medical conditions
2.2a	Have any such medical conditions been optimised as a result of this review?	○Yes /○No
2.3	Has the patient's functional ability been assessed?	○Yes /○No
2.4	Has the patient's cognition been assessed?	○Yes /○No
2.5	Has the impact of incontinence on quality of life been assessed?	○Yes /○No **If NO got to Q2.6**
2.5a	Has Quality of Life been recorded by standard assessment (e.g. Kings Health Questionnaire)	○Yes /○No
	Assessment	
2.6	Has an assessment been performed focussing on finding the cause(s) of urinary incontinence?	○Yes /○No
2.6a	**IF YES**: Who did this assessment?	○GP ○Practice nurse ○district nurse ○Continence specialist ○hospital ward doctor ○hospital ward nurse ○hospital continence specialist (includes surgeon) ○care home nurse
2.7	Is there documented evidence of the following?	
2.7a	• Examination of the abdomen for palpable mass or bladder retention	○Yes /○No
2.7b	• Examination to assess pelvic floor dysfunction	○Yes /○No
2.7c	• Examination of perineum and pelvis to identify prolapse, excoriation and urogenital atrophy **(WOMEN)**	○Yes /○No **Only if female**
2.7d	• Digital rectal examination to examine prostate size **(MEN)**	○Yes /○No **Only if male**
	INVESTIGATIONS	
2.8	Have the following tests been documented:	**Select all that apply**
2.8a	• Renal function	○Yes /○No
2.8b	• Post void residual volume	○Yes /○No
2.8c	• Urinalysis	○Yes /○No
2.8d	• MSU / CSU	○Yes /○No
2.8e	• Abdominal ultrasound	○Yes /○No
2.8f	• Urodynamics	○Yes /○No

2.8g	• Cystoscopy	○Yes /○No

3	**TREATMENT**	
3.1	Is the type or cause(s) of urinary incontinence documented in the notes?	○Yes /○No **If no go to Q3.3**
3.2	What is the type/cause of urinary incontinence?	**Select all that apply**
3.2a	• Stress UI	○Yes /○No
3.2b	• Urge UI	○Yes /○No
3.3c	• Benign prostatic enlargement	○Yes /○No
3.3d	• Neuropathic bladder	○Yes /○No
3.3e	• Urinary tract infection	○Yes /○No
3.3f	• Medication side-effect	○Yes /○No
3.3g	• Constipation (causing retention)	○Yes /○No
3.3h	• Functional or cognitive	○Yes /○No
3.3	Does the patient have a treatment plan recorded in the notes?	○Yes /○No **If no go to Q3.6**
3.4	Does the treatment plan include;	
3.4a	• Referrals to another specialist or service	○Yes /○No
3.4b	• Starting treatment	○Yes /○No
3.4c	• Organised follow up	○Yes /○No
3.4d	• Further investigations	○Yes /○No
3.5	Does documented treatment include;	**Select all that apply**
3.5a	• Pelvic floor exercises	○Yes /○No
3.5b	• Bladder retraining	○Yes /○No
3.5c	• Fluid advice	○Yes /○No
3.5d	• Bladder antimuscarinic medications	○Yes /○No
3.5e	• Alpha blockers or finasteride	○Yes /○No
3.5f	• Prostatic surgery **(MEN)**	○Yes /○No
3.5g	• Urogynaecological surgery **(WOMEN)**	○Yes /○No
3.5h	• Intermittent catheterisation	○Yes /○No
3.5i	• In-dwelling catheterisation	○Yes /○No
3.5j	• Containment – pads	○Yes /○No
3.5k	• Containment – convene, other products	○Yes /○No
3.6	Is the patient catheterised?	○Yes /○No **If no, go to Q 3.7**
3.6a	**IF YES:** Is the reason for catheterisation recorded in the patient's notes?	Yes / No **If no go to Q 3.6c**
3.6b	What was the main reason for catherisation?	○acute retention ○chronic retention with renal impairment ○trauma/surgery ○severe medical illness (fluid balance monitoring) ○severe pressure ulcers / wound ○Reason not documented
3.6c	Is there a documented plan for removal of the catheter?	○Yes /○No
3.7	What consequences of urinary incontinence does the patient have?	**Select all that apply**
3.7a	• Urinary tract infection	○Yes /○No
3.7b	• Urosepsis	○Yes /○No
3.7c	• Pressure ulcers	○Yes /○No

4	Treatment /Care Plan and communication	
4.1	Has the patients own goals/ decisions for treatment or care been documented?	○Yes /○No
4.2	Is there evidence of the treatment plan having been given to the patient (e.g. by patient letter, in discharge summary, through information leaflets)	○Yes /○No
4.3	Are plans for follow up and review clearly documented?	○Yes /○No
4.4	Where relevant, have details of the treatment plan been shared with the patients' carer/relative?	○Yes /○No
4.5	Has the patient been provided with information on causes and treatment of UI?	○Yes /○No
4.6	Has the patient been provided with advice on how to cope with UI?	○Yes /○No **If no, form complete**
4.7	What did this advice include?	
4.7a	• Advice and information on continence products	○Yes / ○No
4.7b	• Advice on skin care	○Yes / ○No
4.7c	• Advice relating to preservation of dignity	○Yes / ○No
4.7d	• Advice relating to preservation of independence	○Yes / ○No
4.7e	• Contact details for relevant support groups and/or helplines	○Yes / ○No
4.7f	• Periodic review of symptoms	○Yes / ○No
4.7g	• Psychological and emotional support	○Yes / ○No

National Audit of Continence Care 2011
Pilot Bowel Audit Proforma
(please complete all questions)

Your Site Code

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*.

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

	DEMOGRAPHIC INFORMATION	Response
A.	Patient numbers	Automatically generated by webtool
B.	Audit date:	Date field
B i	Cycle number	2 digit number
C.	Bowel Proforma	
D.	Patient age	○18-65 / ○65+
E.	Patient gender	○Male / ○Female
F.	Clinical setting	○Hospital medical ward ○Hospital surgical ward ○Hospital elderly care ward ○Hospital outpatient clinic ○GP surgery ○Community clinic ○Care home
G.	Notes audited	○Hospital notes ○GP notes ○Continence specialist records ○Care home care plan
H.	How was faecal incontinence (FI) identified for this audit case/person?	○Routine screening by a provider ○Patient sought help for the problem ○Was only identified through case-finding for this audit ○Other ☐ ○Not Known
1.	**Symptoms**	
1.1	Are the patients faecal incontinence symptoms documented?	○Yes / ○No **If no go to 1.3**
1.2	Do the symptoms of faecal incontinence include:	
1.2a	• Duration of symptoms?	○Yes (symptom documented) ○No (symptom documented as not being present) ○No documentation about this symptom
1.2b	• Frequency of FI?	○Yes / ○No / Not documented
1.2c	• Urgency?	○Yes / ○No / Not documented
1.2d	• Passive leakage?	○Yes / ○No / Not documented
1.2e	• Constipation symptoms?	○Yes / ○No / Not documented
1.2f	• Co-existing urinary incontinence?	○Yes / ○No / Not documented

1.3	Has a stool diary or bowel chart been used to record frequency of incontinence?	○Yes/○no
1.3a	Who completed the stool diary or bowel chart?	○Patient completed ○Provider completed
1.4	If the patient has urinary incontinence, are bladder symptoms documented (e.g. urinary urgency, stress leakage, nocturia)?	○Yes / ○No / ○ Patient does not have urinary incontinence
2	**Medication / Assessment / Investigations**	
2.1	Have the patients' medications been reviewed to assess whether they may be worsening faecal incontinence?	○Yes / ○No / **If no go to 2.2**
2.1a	Have any such medications been altered as a result of this review?	○Yes / ○No
2.2	Have medical conditions that may be relevant to faecal incontinence been reviewed (e.g. diabetes, heart failure, neurological conditions)	○Yes / ○No / ○ Patient does not have any coexisting medical conditions **If no or patient has none go to Q2.3**
2.2a	Have any such medical conditions been optimised as a result of this review?	○Yes / ○No / ○ Patient does not have any coexisting medical conditions
2.3	Has the patient's functional ability been assessed?	○Yes / ○No
2.4	Has the patient's cognition been assessed?	○Yes / ○No
2.5	Has the impact of incontinence on quality of life been assessed?	○Yes / ○No **If NO go to Q2.6**
2.5a	Has Quality of Life been recorded by standard assessment tool?	○Yes / ○No
	Assessment	
2.6	Has an assessment been performed focussing on finding the cause(s) of faecal incontinence?	○Yes / ○No
2.6a	**IF YES:** Who did this assessment?	○GP ○Practice nurse ○District nurse ○Continence specialist ○Hospital ward doctor ○Hospital ward nurse ○Hospital continence specialist (includes surgeon) ○Care home nurse
2.7	At this assessment what was performed:	**Select all that apply**
2.7a	• Examination of abdomen for palpable mass bladder retention?	○Yes / ○No
2.7b	• Examination of perineum and anus?	○Yes / ○No
2.7c	• Digital assessment of sphincter tone?	○Yes / ○No
2.7d	• Rectal examination?	○Yes / ○No
	Investigations	
2.8	What investigations were performed?	
2.8a	• Stool culture for loose stool	○Yes / ○No
2.8b	• Abdominal x-ray	○Yes / ○No
2.8c	• Sigmoidoscopy	○Yes / ○No
2.8d	• Colonoscopy	○Yes / ○No
2.8e	• Abdominal CT or ultrasound	○Yes / ○No
2.8f	• CT enema (virtual colonoscopy)	○Yes / ○No
2.8g	• Endoanal ultrasound	○Yes / ○No
2.8h	• Anorectal physiology	○Yes / ○No
2.9	Is the type or cause(s) of faecal incontinence	○Yes / ○No

	documented in the notes?	**If no go to 3.1**
	IF YES: Are the cause(s) documented as:	**Select all that apply**
2.9a	• Overflow from constipation	○Yes / ○No
2.9b	• Diarrhoea	○Yes / ○No
2.9c	• Medication side-effect	○Yes / ○No
2.9d	• Anal sphincter damage	○Yes / ○No
2.9e	• Anal sphincter damage obstetric-related	○Yes / ○No **Not for males**
2.9f	• Other anorectal condition	○Yes / ○No
2.9g	• Neuropathic bowel (diabetes, neurological conditions etc.)	○Yes / ○No
2.9h	• Functional / cognitive	○Yes / ○No
3	**TREATMENT**	
3.1	Does the patient have a treatment plan?	○Yes / ○No
3.2	Does the **treatment plan** include;	**Select all that apply**
3.2a	• Further investigations	○Yes / ○No
3.2b	• Referrals to another specialist or service	○Yes / ○No
3.2c	• Starting treatment	○Yes / ○No
3.2d	• Organised follow up	○Yes / ○No
3.3	Does documented treatment include;	**Select all that apply**
3.3a	• Pelvic floor / anal sphincter exercises?	○Yes / ○No
3.3b	• Bowel retraining?	○Yes / ○No
3.3c	• Fluid and dietary advice?	○Yes / ○No
3.3d	• Specific treatment for diarrhoea (e.g. antibiotics, treatment for inflammatory bowel disease, removal of polyp/tumour)	○Yes / ○No
3.3e	• Anti-diarrhoeal medication	○Yes / ○No
3.3f	• Laxatives	○Yes / ○No
3.3g	• Enemas or suppositories	○Yes / ○No
3.3h	• Biofeedback	○Yes / ○No
3.3i	• Anorectal surgery	○Yes / ○No
3.3j	• Containment – pads	○Yes / ○No
3.3k	• Containment – bowel management	○Yes / ○No
3.4	Has long-term faecal Incontinence management /advice been given to the patient?	○Yes / ○No
3.5	What did this advice include:	
3.5a	• Advice and information on continence products	○Yes / ○No
3.5b	• Advice on skin care	○Yes / ○No
3.5c	• Advice relating to preservation of dignity	○Yes / ○No
3.5d	• Advice relating to preservation of independence	○Yes / ○No
3.5e	• Contact details for relevant support groups and or helplines	○Yes / ○No
3.5f	• Periodic review of symptoms	○Yes / ○No
3.5g	• Psychological and emotional support	○Yes / ○No
3.6a	Does the patient have any of the following consequences of faecal Incontinence:	
3.6b	Urinary tract infection or urosepsis?	○Yes / ○No
3.6c	Pressure ulcers?	○Yes / ○No
4	**Care Plan / communication**	
4.1	Has the patients own goals/decisions for treatment and care been documented?	○Yes / ○No
4.2	Is there evidence of the treatment plan having been given to the patient (e.g. by patient letter, in	○Yes / ○No

	discharge summary, through information leaflets)	
4.3	Are plans for follow up and review clearly documented?	○Yes / ○No
4.4	Where relevant, have details of the treatment plan been shared with the patients' carer/relative?	○Yes / ○No
4.5	Has the patient been provided with written advice and information on causes and treatment of faecal incontinence?	○Yes / ○No

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2011
Care Home Pilot Audit Organisational Proforma
(please complete all questions)

Your Site Code

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

Organisational Audit

0.1	Cycle number	
1.	**Policies and Commissioning**	
1.1	Does the care home have a written policy for the management of continence?	○Yes / ○No **If NO go to Q1.2**
	Does this written policy include:	
1.1a	• Training for staff in continence care?	○Yes / ○No
1.1b	• Assessment and treatment of incontinence?	○Yes / ○No
1.1c	• A means for regular audit of continence care?	○Yes / ○No
1.2	Does your care home have a contract for resident placement with the NHS or Local Authority, which includes a quality indicator relating to;	
1.2a	Catheters	○Yes / ○No / ○Not known
1.2b	Urinary Incontinence	○Yes / ○No / ○Not known
1.2c	Faecal incontinence	○Yes / ○No / ○Not known
1.3	Are there any financial penalties or additional payments linked to the achievement of the continence quality indicators in 1.2 questions above?	○Yes / ○No / ○Not known
1.4	Do you have any written guidance or protocols for staff on:	
1.4a	Care of catheters	○Yes / ○No
1.4b	Assessment, management and/or treatment of urinary incontinence	○Yes / ○No
1.4c	Assessment, management and/or treatment of faecal incontinence	○Yes / ○No
1.4d	Management and treatment of urinary tract infections?	○Yes / ○No
1.5	How long do your residents wait from referral to being seen for an assessment visit by the Continence Nurse Specialist? ***Use the last resident you referred or use usual waiting time?***	○ 1-2 weeks ○ 2-4 weeks ○ 4-8 weeks ○ 8-18 weeks ○ Greater than 18 weeks

1.6	Care homes providing personal care only: How long do your residents have to wait for a continence assessment visit by a district nurse? ***Use the last resident you referred or usual waiting time***	○ Within 3 days ○ Within 1 week ○ Within 2 weeks ○ Longer than 2 weeks ○ Do not provide personal care
1.7	When you request that a GP sees a resident for 'continence related problems', how long do your residents have to wait? ***Use the last resident you referred or usual waiting time***	○ Within 3 days ○ Within 1 week ○ Within 2 weeks ○ Longer than 2 weeks
2	**Clinical Protocols**	
2.1	Do you ask screening question(s) relating to bladder and bowel problems as part of the pre admission assessment?	○Yes / ○No
2.2	Do you ask screening question[s] relating to bladder and bowel problems as part of the assessment on admission?	○Yes / ○No
2.3	Is there a protocol or pathway that is initiated when a patient responds to the screening question(s) that they have a bladder or bowel problem?	○Yes / ○No / ○Not known
2.4	Is there a written protocol for providing an initial assessment for all people who indicate that they have problems with urinary and/or faecal continence?	○Yes / ○No
2.5	Is there a lead link person/ nurse for continence in your care home?	○Yes / ○No / ○Not known
3	**Training**	
3.1	Is there a structured programme of staff training on:	
3.1a	• Promoting and managing continence?	○Yes / ○No / ○Not known
3.1b	• Treatment of continence?	○Yes / ○No / ○Not known
3.2	Does the staff training target:	
3.2a	Care workers	○Yes / ○No
3.2b	Nurses	○Yes / ○No
3.2c	Continence link nurses/ care workers	○Yes / ○No
3.3	Is the staff training :	○One off (such as at induction/starting at care home) ○Rolling programme(annual refresher or different sessions over a time period)
3.4	Nursing homes only: Do you provide training for your nurses in how to undertake continence assessments?	○Yes / ○No / ○Nursing home
4	**Privacy and Dignity**	
4.1	Do all of your environments provide:	
4.1a	• Privacy around the toilet area	○Yes / ○No
4.1b	• Easily accessible and identifiable toilet facilities	○Yes / ○No
4.1c	• Appropriate aids to toileting (frames /rails etc)	○Yes / ○No
4.1d	• Privacy when staff speak to residents in confidence	○Yes / ○No
4.1e	• Hand washing after toileting	○Yes / ○No
5	**Audit**	
5.1	Is the bladder or bowel care delivered in the care home regularly audited?	○Yes / ○No **If NO go to section 6**
5.2	What aspect of the care is audited:	
5.2a	• Use of catheters and their management?	○Yes / ○No
5.2b	• Assessment, management and/or treatment of urinary incontinence?	○Yes / ○No
5.2c	• Assessment, management and/or treatment of faecal incontinence?	○Yes / ○No
5.2d	• Privacy and dignity in managing continence?	○Yes / ○No
5.2e	• Use of continence management plans and toileting regimes?	○Yes / ○No

6	**Continence Products**	
6.1	What is the daily limit on the number of continence products/ pads provided for each of your residents by the:	
6.1a	NHS	Number: ○No limit **If there is a limit answer Q 6.2**
6.1b	Local council	Number: ○No limit **If there is a limit answer Q 6.2**
6.2	If there is a limit can the care home purchase for their residents:	
6.2a	• All products / pads	○Yes / ○No
6.2b	• Top up products / pads	○Yes / ○No
6.3	Are products supplied on the basis of clinical and resident need rather than cost?	○Yes / ○No
6.4	Do residents have access (on the NHS) to the product of their choice (such as washable briefs)?	○Yes / ○No
6.5	Are you able to request an assessment or review for additional products if this is required by the resident?	○Yes / ○No
6.6	Does your local primary care trust (PCT) have a protocol stating that a continence assessment should be carried out before products are provided to residents?	○Yes / ○No
7	**Patient Carer Information and Support**	
7.1	Does the care home/PCT/community continence provide information about bladder and bowel care to residents and families?	○Yes / ○No

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2011
Care Home Pilot Audit Bladder Proforma
(please complete all questions)

Your Site Code

Instructions for completion:
9. Please use a ball-point 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*.

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

CLINICAL BLADDER AUDIT

	DEMOGRPHIC INFORMATION	**Response**
A.	Patient audit number	Automatically generated by webtool
B.	Audit date	
C.		
D.	Patient age	○18-65 / ○65+
E.	Patient gender	○Male / ○Female
1.	**Symptoms**	
1.1	How was this resident identified as being incontinent of urine?	○During pre- admission assessment ○During admission assessment ○Identified by care home following admission ○Resident sought help for the problem? ○Was only just identified through case-finding for this audit? ○Other (what)
1.2	Has the resident's continence symptoms been documented in the care plan?	○Yes / ○No
2	**Management / Assessment / Investigations**	
2.1	Has the resident or the care home been asked to complete a bladder diary by the GP, District Nurse or Continence Nurse Specialist?	○Yes / ○No
2.2	Have the residents' medications been reviewed by the GP; District Nurse; continence nurse specialist or Pharmacist, to assess whether they may be worsening urinary incontinence?	○Yes / ○No / ○Not taking medication If no or not taking any medication go to 2.7
2.2a	Have any medications been altered as a result of this review?	○Yes / ○No
2.3	Have medical conditions that may be relevant to urinary incontinence been reviewed by the GP; District Nurse or continence nurse specialist (e.g. diabetes, heart failure, or stroke)	○Yes / ○No / ○Resident has none of these conditions **If no or none of these conditions go to 2.4**
2.3a	Have any medical conditions been improved/optimised as a result of this review?	○Yes / ○No

2.4	Has the resident's cognition/ awareness been assessed?	○Yes / ○No
2.5	Has the resident's physical function and ability to self-toilet been assessed?	○Yes / ○No
2.6	Has the impact of incontinence on the resident's quality of life been assessed? e.g. social isolation, low self-esteem, missing activities in the care home, missing trips out)	○Yes / ○No
	Investigations	
2.7	Has a urine dip stick been done?	○Yes / ○No
2.7a	In care homes providing personal care only: Who has done the urine dip stick?	○District nurse ○Continence Nurse Adviser ○Other
2.8	Has an assessment been performed to find the cause of the urinary incontinence?	○Yes / ○No **If NO go to Q2.9**
2.8a	Who did this assessment?	○Nurse in care home ○District Nurse ○GP ○Continence Nurse Specialist ○Hospital
2.9	Is there evidence in records of any of the following **routine tests** being carried out **in the care home**:	
2.9a	Mid stream specimen of urine?	○Yes / ○No
2.9b	Catheter specimen of urine?	○Yes / ○No/ ○No catheter
3	**Treatment**	
3.1	Has the GP, District Nurse, Continence Advisor or hospital identified/recorded the type or cause of the urinary incontinence?	○Yes / ○No **If NO go to Q3.3**
3.2	What is the type/cause:	
3.2a	Stress urinary incontinence?	○Yes / ○No
3.2b	Urge urinary incontinence?	○Yes / ○No
3.2c	Enlarged prostate?	○Yes / ○No
3.2d	Neuropathic bladder?	○Yes / ○No
3.2e	Urinary tract infection?	○Yes / ○No
3.2f	Medication side-effect?	○Yes / ○No
3.2g	Constipation (causing retention of urine)?	○Yes / ○No
3.2h	Functional or cognitive deterioration?	○Yes / ○No
3.3	Is the resident having any of the following treatment:	
3.3a	Pelvic floor exercises?	○Yes / ○No
3.3b	Bladder retraining?	○Yes / ○No
3.3c	Fluid advice?	○Yes / ○No
	Medicines	○Yes / ○No
3.3d	Bladder medication?	○Yes / ○No
3.3e	Prostate medication?	○Yes / ○No
	Surgery	○Yes / ○No
3.3f	Prostatic surgery?	○Yes / ○No / ○Not known
3.3g	Urogynaecological surgery?	○Yes / ○No / ○Not known
	Catheter	○Yes / ○No
3.3h	Intermittent catheterisation?	○Yes / ○No
3.3i	In-dwelling catheterisation?	○Yes / ○No
	Product use	○Yes / ○No
3.3j	Containment – pads?	○Yes / ○No
3.3k	Containment sheath, other products?	○Yes / ○No
3.4	Is the resident catheterised?	○Yes / ○No **If YES answer Q3.5** **If NO go to Q3.8**
3.5	Is the reason for catheterisation clearly recorded?	○Yes / ○No

		If NO go to Q3.7
3.6	Is this reason because of:	
3.6a	Sudden inability to pass any urine [acute retention]?	○Yes / ○No
3.6b	Long standing inability to pass urine [chronic retention with kidney problems]?	○Yes / ○No
3.6c	Serious accident/ trauma/ or following surgery?	○Yes / ○No
3.6d	Deteriorating health due to illness?	○Yes / ○No
3.6e	Severe pressure sores or a wound?	○Yes / ○No
3.6f	Was admitted with a catheter in place	○Yes / ○No
3.7	Is there a documented plan for removal of the catheter?	○Yes / ○No
3.8	Does the resident have any consequences of urinary incontinence such as pressure sores?	○Yes / ○No
4	**Treatment and care plans**	
4.1	Has a treatment plan been given to the resident (e.g. by letter, or in the hospital discharge summary, by the GP, District nurse, or Continence Nurse Specialist)	○Yes / ○No **If NO go to Q4.2**
4.1a	Is there evidence that their treatment plan is included in the care plan?	○Yes / ○No
4.1b	Are plans for follow up or review clearly documented in the treatment plan?	○Yes / ○No
4.1c	Is the resident's choice or decisions recorded in the treatment plan?	○Yes / ○No/ ○Not able to decide on own goals
4.2	Is the resident's choice or decisions recorded in the care plan?	○Yes / ○No/ ○Not able to decide on own goals
4.3	Does the care plan state how to:	
4.3a	Maintain privacy whilst providing continence care?	○Yes / ○No
4.3b	Provide continence products that meet the resident's need?	○Yes / ○No
4.3c	Provide skin care?	○Yes / ○No
4.3d	Check for signs of urinary infection?	○Yes / ○No
4.3e	Recognise signs or provide advice of when the resident likes to go to the toilet?	○Yes / ○No
4.3f	Ensure the resident has drunk and eaten enough to help with continence?	○Yes / ○No
4.4	Is there a follow up or review date clearly documented in the care plan?	○Yes / ○No **If NO go to Q4.5**
4.4a	Has the care plan been reviewed on this date?	○Yes / ○No / ○No, but review date in the future
	Information	
4.5	Has the resident and/or their family been provided with written advice and information about urinary incontinence such as causes and treatment, how to cope, caring for skin, access to support groups, and helpline numbers	○Yes / ○No / ○Not applicable due to lack of capacity

Royal College of Physicians
Setting higher medical standards

National Audit of Continence Care 2011
Care Home Pilot Audit Bowel Proforma
(please complete all questions)

Your Site Code

Instructions for completion:
11. Please use a ball-point pen for all sections.
12. 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

CLINICAL BOWEL AUDIT
Care home - residential or nursing? Auditing care home records?
Minimum 10

	DEMOGRPHIC INFORMATION	**Response**
A.	Patient audit number	Automatically generated by webtool
B.	Audit date	
C.		
D.	Patient age	○18-65 / ○65+
E.	Patient gender	○Male / ○Female
1.	**Symptoms**	
1.1	How was this resident identified as being incontinent of their bowels (faecal incontinence)?	○During pre- admission assessment ○During admission assessment ○Identified by care home following admission ○Resident sought help for the problem ○Was only just identified through case-finding for this audit ○Other (what) ○Don't know
1.2	Has the resident's bowel symptoms been recorded in the care plan?	○Yes / ○No
1.2a	Is the resident also incontinent of urine?	○Yes / ○No
2	**Medication / Assessment / Investigations**	
2.1	Has the GP, District nurse, or continence nurse specialist asked you to use a stool diary or chart to record frequency of incontinence for this resident?	○Yes / ○No
2.2	Have the resident's medications been reviewed by the GP, District Nurse, Continence specialist nurse or pharmacist, to assess whether they may be worsening faecal incontinence?	○Yes / ○No / ○Not taking any medication **If NO go to Q2.3**
2.2a	Have any medications been altered as a result of this review?	○Yes / ○No/ ○Not taking any medication
2.3	Have medical conditions that may be relevant to faecal incontinence been reviewed by the GP, District Nurse,	○Yes / ○No / ○Resident has none of these

	Continence Nurse Specialist (e.g. diabetes, heart failure, or stroke)	**If No or none of these go to Q2.4**
2.3a	Have any medical conditions been improved/optimised as a result of this review?	○Yes / ○No / ○Resident has none of these
2.4	Has the resident's cognition/ awareness been assessed?	○Yes / ○No
2.5	Has the resident's physical function and ability to self-toilet been assessed?	○Yes / ○No
2.6	Has the impact of incontinence on the resident's quality of life been assessed? e.g. social isolation, low self-esteem, missing activities in the care home, missing trips out)	○Yes / ○No
2.7	Is there documented evidence of rectal examination carried out by a nurse in the care home, or district nurse, continence nurse specialist or GP?	○Yes / ○No
2.8	Has an examination and assessment been performed to find the cause of faecal incontinence?	○Yes / ○No
2.9	Who did this assessment?	○Nurse in care home ○District Nurse ○GP ○Continence nurse specialist ○hospital
3	**Treatment**	
3.1	Did the resident have a treatment plan provided by the GP, district nurse, continence nurse specialist or hospital?	○Yes / ○No
3.2	Has the GP, district nurse, continence nurse specialist or hospital identified/recorded the type or cause of the resident's faecal incontinence?	○Yes / ○No
3.3	Is the type/cause of faecal incontinence recorded as:	
3.3a	• Overflow from constipation	○Yes / ○No
3.3b	• Diarrhoea	○Yes / ○No
3.3bi	If diarrhoea, has the cause of diarrhoea been recorded?	○Yes / ○No
3.3c	• Medication side-effect	○Yes / ○No
3.3d	• Anorectal condition (e.g. sphincter damage, anorectal surgery, anorectal cancer, rectal prolapse)	○Yes / ○No
3.3e	• Neurological conditions (e.g. stroke, multiple sclerosis, Parkinson's Disease)	○Yes / ○No
3.3f	• Functional / cognitive deterioration	○Yes / ○No
3.4	Does the treatment for the resident include:	
3.4a	• Pelvic floor / anal sphincter exercises?	○Yes / ○No
3.4b	• Bowel retraining?	○Yes / ○No
3.4c	• Fluid and dietary advice?	○Yes / ○No
	Medicines	○Yes / ○No
3.4d	• Specific treatment for diarrhoea (eg antibiotics, treatment for Irritable Bowel Disease)?	○Yes / ○No
3.4e	• Antidiarrhoeal medicines or tablets?	○Yes / ○No
3.4f	• Laxatives?	○Yes / ○No
3.4g	• Enemas or suppositories?	○Yes / ○No
	Surgery	○Yes / ○No
3.4h	• Anorectal surgery?	○Yes / ○No
	Product use	○Yes / ○No
3.4i	• Containment – pads?	○Yes / ○No
3.4j	• Containment – bowel management?	○Yes / ○No
3.5	Does the resident currently have any consequences of faecal incontinence such as pressure sores?	○Yes / ○No
4	**Care plans / Communication**	
4.1	Has a treatment plan been given to the resident (e.g. by letter, or in the hospital discharge summary, by the GP,	○Yes / ○No

	District nurse, or Continence Nurse Specialist)	
4.1a	Is there evidence that their treatment plan is included in the care plan?	○Yes / ○No
4.1b	Are plans for follow up or review clearly documented in the treatment plan?	○Yes / ○No
4.1c	Is the resident's choice or decisions recorded in the treatment plan?	○Yes / ○No/ ○Not able to decide on own goals
4.2	Is the resident's choice or decisions recorded in the care plan?	○Yes / ○No / ○Not able to decide on own goals
4.3	Does the care plan state how to:	
4.3a	• Maintain privacy whilst providing continence care?	○Yes / ○No
4.3b	• Provide continence products that meet the resident's need?	○Yes / ○No
4.3c	• Provide skin care?	○Yes / ○No
4.3d	• Provide psychological and emotional support?	○Yes / ○No
4.3e	• Recognise signs or provide advice of when the resident likes to go to the toilet?	○Yes / ○No
4.3f	• Ensure the resident has drunk and eaten enough to help with continence?	○Yes / ○No
4.3g	• Preserve the resident's independence	○Yes / ○No
4.4	Is there a follow up or review date clearly documented in the care plan?	Yes / No
4.4a	Has the care plan been reviewed on this date?	Yes/ No / ○No, but review date in the future
	Information	
4.5	Has the resident and/or their family been provided with written advice and information about faecal incontinence such as causes and treatment, how to cope, caring for skin, access to support groups, and helpline numbers?	○Yes / ○No / ○Not applicable due to lack of capacity

Appendix 3

NAAC 2011: National Audit of Continence Care 2011

Pilot Audit Evaluation

Thank-you for all your work participating in the pilot audit

Please could we ask you to complete this questionnaire, to help us evaluate the pilot audit? Your feedback and comments will help to make the audit better.

To demonstrate which response applies please put a cross in the relevant box(es) - **X**

SITE: (Insert Site ID)		
Name of Organisation:		
What information did you complete for the pilot audit? X all that apply	**Organisational proforma**	
	Bladder proforma	
	Bowel proformas	
	Reporting function	

1: Web Tool

1.1 How easy was it to access the web tool from your computer using the link provided?		
	Please indicate	**If you ticked "Difficult", please tell us about the difficulties you faced:**
Easy		
Difficult		

2: Web tool guide

2.1 Did you read the web tool user notes for the audit? (If No go to 3)	**Yes**		**No**	

2.2 If yes, how would you rate the usefulness of the web tool guide?	***Please indicate***	**2.3 If 'not useful', please tell us why?**
Useful		
No opinion		
Not useful		

3: Help notes

3.1 Did you read the help notes for the audit? (If No go to 4)	**Yes**		**No**	

3.2 If yes, how would you rate the usefulness of the help notes?	***Please indicate***	**3.3 If 'not useful', please tell us why:**
Useful		
No opinion		
Not useful		

4: Accessing support from the National Audit of Continence Care project team

4.1 Did you find it easy to get the support you needed from the audit team?	***Please indicate***	**4.2 Any comments:**
Yes		
No		

5: Data entry

5.1 Did you have any problems entering the data into the web tool.	***Please indicate***	**5.2 If you ticked "Yes", please tell us what kinds of problems you encountered:**
Yes		
No		

6: Data collection

	6.1 How easy was it to complete the information for the sections: ((Please X one option only per section)					6.2 Please provide *any* comments below:
Section	**Easy?**	**Some data Was difficult to collect?**	**All or most of it was difficult to collect?**	**Not relevant i.e. did not collect this**		
Organisational proforma						
Bladder proforma						
Section 1. Assessment						
Section 2. Investigations						
Section 3. Treatment						
Section 4. Care Plan / Communication						
Bowel						
Section 1. Assessment						
Section 2. Investigations						
Section 3. Treatment						
Section 4. Care Plan / Communication						

Please continue on another page if you have more comments.

7: Statistics (the reporting function showing you results/statistics from the audit)

7.1 Did you use the reporting function once you had entered all your data?	**Yes**		**No**	

7.2 If yes, how easy was it to use:	***Please indicate***	**7.3 Any comments:**
Easy		
Not very easy		

7.4 How useful was the information given in the report:	***Please indicate***	**7.5 Any Comments**
Useful		
Not very useful		

7.6 Could you use this audit and information to action change?	**Yes**		**No**	
Comments				

7.7 Could you use this audit to continuously quality assess your service if it were available to you at all times as a webtool?	**Yes**		**No**	
7.8 If yes, how often would you do audit cycles?	**Yes**		**No**	

7.9 Do you think this audit has value as an educational tool?	***Please indicate***	**7.10 Any Comments**
Yes		

No		

8: General comments

8.1 Do you think anything should be altered in the continence audit?	**Yes**		**No**	
Include any suggestions about issues that should have been raised or changes that should be made to the question phrasing on the data collection tools; support information or web tool help notes. Please continue on the back (if posted) or on a separate page (if emailed) as necessary				

Once completed please email: nacc@rcplondon.ac.uk or post to: NACC2011, CEEU, Royal College of Physicians, 11 St Andrews Place, Regent's Park, London NW1 4LE

Thank-you for participating in the pilot audit and completing the questionnaire