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## Peer review

# How is the quality of continence care determined in Australian residential aged care settings? A content analysis of accreditation reports

## Abstract

Few research papers have been published about the quality of continence care residents of aged care facilities receive or the evaluative criteria assessors use to determine a facility's performance against continence care standards. The objectives of the study were to identify the descriptors used to report the quality of continence care in accreditation reports and compare these descriptors with a list of international recommendations. Ten per cent of accreditation reports in one Australian state were reviewed and analysed to establish the frequency of descriptors used by assessors when reporting the quality of continence care. Each identified factor was then compared against international recommendations for managing incontinence in frail, older adults. Eighteen descriptors were identified, but only three were congruent with international recommendations. They were: the frequency of incontinence, residents' personal care goals and treatment preferences, and environmental factors. Reports lacked information about the quality and outcomes of continence assessments, what constituted resident/representative satisfaction, and a "system" or "process". As accreditation reports lacked information about care processes for actively diagnosing and managing residents' continence care needs, it may be useful for assessors to use a checklist of continence care recommendations based on international guidelines.

*Keywords: urinary incontinence, faecal incontinence, residential facilities, nursing home, elderly, health care quality, accreditation.*

## Background

Many people who live in residential aged care facilities (RACF) need help from carers for toileting and to manage incontinence. The majority have urinary and faecal incontinence. In 2003, the cost to the Australian Government for the care of people living in RACF who had incontinence or were dependent on staff for toileting was estimated to be \$1.3 billion, which was 32% of the total basic RACF subsidy of \$4.0 billion<sup>1</sup>. The cost, which does not include the costs of pads and other continence aids, is projected to increase by around 200% by 2030 because of the population ageing and the associated increased need for formal care<sup>1</sup>.

Complaints to the Aged Care Complaints Scheme (the Scheme) about continence management are common. The Scheme operates under the auspices of the Office of Aged Care Quality and Compliance (OACQC) in the Department of Health and Ageing (DoHA). The Scheme received 8130 complaints relating to Australian Government-subsidised RACF between 2010 and 2011. Of these, 3167 (39%) related to health and personal care, including continence management<sup>2</sup>.

The *Aged Care Act 1997* provides standards of care for Australian RACF and is overseen by the Australian Aged Care Standards and Accreditation Agency (ACSAA). The RACF sector in Australia is highly regulated and funding depends on a facility's adherence to a set of accreditation standards. The Aged Care Accreditation Standards (the Accreditation Standards) address:

- Management systems, staffing and organisational development.
- Health and personal care.
- Resident lifestyle.
- The physical environment and safe systems.

A number of expected outcomes nest within each standard. The expected outcome of Accreditation Standard 2.12 (Health and Personal Care) states *Residents' continence is managed effectively*<sup>3</sup>. A difficulty arising from this standard is the absence of an

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operational definition for the term "effective continence care", which leaves open the possibility that the term could mean one set of policies and practices to some staff members and a different set to others. While the ACSAA has recently developed a number of resources to support the accreditation process, for example a Results and Processes Guide and a series of assessment modules<sup>4</sup>, it remains unclear how Aged Care Assessors (assessors) interpret the information and the standards to evaluate continence care.

Assessors typically have experience in health, quality or management. They conduct periodic full audits, as well as unannounced visits to monitor continuing compliance with standards. They may review documentation processes, observe the environment and interview residents and their representatives, management, staff and other relevant people. Facilities are audited and accredited every three years and failure to meet one or more of the standards can lead to accreditation being revoked. Information about the outcomes of each RACF accreditation, including a list of sanctioned RACF, is publicly available on a DoHA website<sup>5</sup>.

In 1998, the World Health Organization sponsored the first International Consultation on Incontinence (ICI) which systematically reviewed urinary incontinence and raised general awareness of symptoms, evaluation, treatment and prevention<sup>6</sup>. The ICI promotes active diagnosis and treatment, and recommends that treatment is individualised and guided by an assessment that identifies the most likely clinical diagnosis, and that factors that cause or contribute to incontinence are documented. The latest ICI in 2008, the fourth Paris ICI,

*Box 1. International Consultation on Incontinence recommendation of factors for assessing and managing incontinence in frail, older people<sup>7</sup>.*

- The frequency of incontinence
- Personal goals of care or treatment preferences
- Haematuria
- Comorbid conditions
- The psychosocial impact of the condition
- Functional status
- Environmental factors
- Medications that could cause or worsen incontinence
- Depression
- Cognitive status
- Faecal loading or impaction
- Post-voiding residual volume
- Nocturia/nocturnal polyuria/primary sleep problems

updated the review of continence care for frail older people<sup>7</sup>. The 13 key factors recommended by the ICI for assessing and managing incontinence in frail, older people are shown in Box 1. These are the basis of the resource material provided by the ACSAA. Hence, the quality of continence care and its evaluation should be evidence-based and accreditation reports should contain information about the quality, content and outcomes of continence care.

## Objectives

The objectives of the study were to identify the descriptors used to report the quality of continence care in accreditation reports and compare those descriptors with a list of international recommendations for managing incontinence in frail, older people.

## Methods

A sample of 10% (n=87) of the 870 publicly available accreditation reports from RACF in New South Wales (NSW), Australia, was selected for analysis. NSW was chosen because it had the largest number of RACF at the time of the analysis. The names and postcodes of all RACF in the state were identified using the *DPS Guide to Aged Care*<sup>8</sup>. Using the Accessibility/Remoteness Index of Australia (ARIA)<sup>9</sup> to determine the location of each RACF, all NSW RACF were then grouped into one of five Australian Institute of Health and Welfare (AIHW) geographic locations, namely: major cities, inner regional areas, outer regional areas, remote areas and very remote areas<sup>10</sup>. Next, AIHW statistics about RACF in NSW were used to identify the number of RACF in each location, indicating that 540 were in major cities, 237 were in inner regional areas, 88 in outer regional, seven in remote areas and none in very remote areas. Ten per cent of RACF from each of these groups were then selected by choosing every eighth RACF until the required number was obtained. This process resulted in a sample of 54 accreditation reports from RACF in major cities, 23 reports from RACF in inner regional areas; nine from outer regional areas; and one from remote areas.

The accreditation report for each selected RACF was downloaded from the ACSAA website and identifying information was removed. The documentation in each report for performance against Accreditation Standard 2.12 was entered into QSR International's NVivo 9 software program for data management<sup>11</sup>. NVivo9 is a qualitative data analysis computer software package that is used to analyse non-numerical or text data. It allows users to classify, sort and arrange information, and examine relationships in data.

The data were analysed in two stages. The first stage was inductive content analysis whereby the first 10 reports were read

to gain an overall impression of the content and structure of text data. Then the text data within the 87 reports was coded or broken down into manageable categories at a sentence level. The existence and frequency of descriptors most often represented by words or phrases in text were identified. Descriptors that addressed common factors were grouped and coded with terms used in the text. Once the descriptors were identified, they were listed and rated from most to the least frequently documented. The second analysis stage involved comparing factors identified from stage one against a list of 13 key factors recommended by the ICI in its most recent guidelines for assessing and managing continence in frail, older adults<sup>7</sup>. Approval to conduct the analysis was obtained from Deakin University Human Research Ethics Committee.

## Results

The accreditation reports indicated all 87 RACF met Accreditation Standard 2.12. Most reports opened with a statement that a system or process was in place to meet the continence care needs of each resident, and concluded with a statement that residents or their representatives were satisfied with continence care. Hence, the structure and content of each report was brief, contained similar information and was formulaic in nature. Content analysis identified 18 factors from assessors' documentation about RACF performance against Accreditation Standard 2.12 (Table 1). The four most frequently documented descriptors were:

1. Residents are assessed to identify their continence care needs.
2. Residents and representatives are satisfied with continence care.
3. A system/process is in place to meet residents' continence care needs.
4. The RACF has a stock/supply of continence aids.

More than half, 57 (66%), of the reports contained a statement indicating that the RACF had a system or process in place to meet residents' continence care needs, and 79 (91%) of reports indicated each resident was assessed to identify their continence care needs. Table 2 lists the factors assessors indicated staff assessed. The most frequently documented assessment factor was whether staff monitored bladder and bowel function of each resident, which was documented in 38 (44%) reports. The least frequently documented assessment factors were whether staff used: a validated assessment tool, identified reversible causes of incontinence, or assessed hydration status, which were each documented once.

Thirty-three reports (38%) indicated that residents had individualised bowel management programmes, and 26 (22%)

Table 1. The frequency and percentage of factors documented by Assessors in Accreditation reports.

Factors assessors documented	Number of statements n=87 (%)
Residents are assessed to identify their continence care needs	79 (91)
Residents and representatives are satisfied with continence care	73 (84)
The facility has a system or process in place to meet residents' continence care needs	57 (66)
The facility has a stock/supply of continence aids	56 (64)
Staff have access to training/education on incontinence	38 (44)
Staff use external sources of support and information	34 (39)
Residents have individualised bowel management programmes	33 (38)
Residents have individualised toileting assistance programmes	26 (30)
Continence care is communicated	18 (21)
Equipment to promote continence is available	18 (21)
Staff know residents' individual needs	16 (18)
Staff provide assistance with continence aids	7 (8)
The facility is odour-free	7 (8)
Staff supervise continence care	6 (7)
Toilets are accessible	6 (7)
Information is provided to residents and representatives	2 (2)
Pelvic floor muscle exercises and physiotherapy are available	2 (2)
Staff promote residents' independence	1 (1)

reports documented that residents had individualised toileting assistance programmes. Twenty-two (25%) reports indicated that residents were consulted or that their continence care preferences were identified. In addition, the majority of reports (73; 84%) documented that residents or their representatives were satisfied with the continence care provided. Most reports indicated residents and representatives "stated" they were satisfied, which suggests assessors conducted interviews to elicit their level of satisfaction with continence care. No information was provided about how residents and representatives were selected or the questions they were asked.

Table 2. The frequency and percentage of assessment factors documented by Assessors in Accreditation reports.

Assessment factors assessors documented	Number of statements n=87 (%)
Staff monitor residents' bladder and bowel function	38 (44)
Staff consult with residents and identify their preferences	22 (25)
Staff monitor residents for UTI	19 (22)
Staff identify residents' toileting needs	13 (15)
Medical staff are consulted	7 (8)
Staff assess/monitor residents' skin health	6 (7)
Staff assess residents' prior history	5 (6)
Staff assess residents' continence aid needs	4 (5)
Staff use a validated assessment tool	1 (1)
Staff identify reversible causes of incontinence	1 (1)
Staff assess residents' hydration status	1 (1)

More than half of the reports, 56 (64%), indicated the RACF had a stock/supply of continence aids. Assessors documented whether:

- The stock/supply of continence aids included aids of different sizes and types.
- The facility had a process to ensure residents were assessed for appropriate aids.
- The facility had a process to review residents' needs for different aids.
- The facility had a process to order and distribute aids.
- Specific staff were responsible for overseeing the allocation of aids.

Staff access to education and training about incontinence was documented in 38 (43%) reports. Assessors commonly documented that education and training was provided by representatives of companies that produced or supplied continence aids, and the companies were an external source of support for advice and assistance about incontinence.

Three of the 13 factors recommended by the ICI<sup>7</sup> were documented in accreditation reports under Accreditation Standard 2.12 (Table 3). They included:

- 1) The frequency of incontinence.
- 2) Residents' personal goals of care or treatment preferences.
- 3) Environmental factors.

None of the reports contained information about whether or not staff assessed the impact of incontinence on residents' quality of life, or whether continence status was caused or exacerbated by their functional status, medication, cognitive status, depression, or by faecal loading or impaction.

## Discussion

This study, using content analysis of accreditation reports, identifies how continence care is documented and evaluated as part of the regular accreditation process for the RACF sector. Accreditation reports contained information about 18 continence management factors, but only three such factors were congruent with ICI recommendations<sup>7</sup> for managing incontinence in frail, older adults. The findings suggest ICI recommendations<sup>7</sup>, which promote active incontinence diagnosis and treatment, were not used to guide the evaluation of continence care in RACF.

The ICI recommends that the management of incontinence be guided by a comprehensive continence assessment that identifies causative and contributing factors, including reversible causes<sup>7</sup>. Although it was documented in the majority of reports that there was a process, system or assessment process to identify continence care needs, reports did not define what was meant by the terms "system" or "process". They also lacked information about the factors that were considered in the assessment. Hence, it is unclear if factors that caused or contributed to incontinence were identified and addressed in the system/process. In the absence of such information, it is possible that assessors positively appraised systems/processes or assessments that addressed continence aid requirements only and, hence, evaluative processes were biased to continence containment.

Evaluation processes appear weighted to policies and practices that promote containment, rather than policies and practices that promote active diagnosis, treatment and management. This may be because some assessors positively appraised education and training about incontinence from pad and product manufacturers. Recently, pad and product manufacturers have established a lead role as education providers and support about continence management in RACF but this reliance on pad and product companies as educators may represent a conflict of interest. It is probable that education and support from this source reinforces beliefs and behaviours about containment rather than policies and practices that promote active diagnosis, treatment and management. If evaluation processes to determine the quality of care are also weighted towards pad use and support from pad manufacturers, accreditation processes may inadvertently endorse, promote and reinforce containment, rather than promote continence.

Table 3. International Consultation on Incontinence recommendation of factors for assessing and managing incontinence in frail, older people<sup>7</sup> and number of statements in Accreditation reports addressing these factors.

International Consultation on Incontinence factors	Number of statements in Accreditation reports addressing International Consultation on Incontinence recommendation factors
1. The frequency of incontinence	38 statements indicated staff monitored residents' bladder and bowel function
2. Personal goals of care or treatment preferences	22 statements about residents'/representatives' involvement in assessment/care plan 79 statements about residents'/representatives' satisfaction
3. Environmental factors	Six statements – all related to toilet accessibility
4. Co morbid conditions	One report documented that staff assessed residents' comorbidities
5. Haematuria	No documentation
6. The psychosocial impact of the condition	No documentation
7. Functional status	No documentation
8. Medications that could cause or worsen incontinence	No documentation
9. Depression	No documentation
10. Cognitive status	No documentation
11. Faecal loading or impaction	No documentation
12. Post-void residual volume (PVR)	No documentation
13. Nocturia/nocturnal polyuria/primary sleep problems	No documentation

The ICI recommends a medical assessment be undertaken to determine the type and causes of incontinence and nocturia, and to determine the appropriateness of pharmacological, behavioural or surgical therapy<sup>7</sup>. In the current study, only one RACF report contained information about medical input relating to residents' incontinence. As the majority of ICI recommendations<sup>7</sup> rely on medical input, reports should contain information about medical involvement in continence care.

The ICI also recommended that continence care should incorporate an individual's continence care preferences<sup>7</sup>. Only 25% of reports indicated whether residents and/or their representatives were consulted about their continence care preferences such as whether they wanted to use the toilet independently, wear a pad, or sleep uninterrupted during the night. Arguably, individual care preferences should form the basis of care and the evaluation of such care in RACF.

Most reports did contain a statement indicating that residents and their representatives were satisfied with their continence care. However, there are limitations associated with methods to obtain information about how satisfied residents are with continence care. Data from the United States of America (USA) suggests that many residents report being satisfied with the

care they receive for incontinence even when such care is not consistent with their preferences<sup>12-15</sup>. Responses to questions about satisfaction with continence care may be influenced by an elderly person's vulnerability, dependence and fear of reprisal if they voice dissatisfaction. Some research suggests that the way in which questions are framed may also affect the accuracy of individual responses. For example, two studies found that open-ended questions yielded more accurate responses than closed questions that required a "yes" or "no" response<sup>15,16</sup>. Most reports in the current study did not document the methods used to obtain information about the satisfaction of residents and their representatives. As satisfaction is an elusive concept and is difficult to define and measure, especially among vulnerable, cognitively impaired individuals who are dependent on care, further light should be shed on the process used to evaluate this important indicator of the quality of care.

A further consideration is that many residents do not expect their continence status to improve, and have little hope their care will improve<sup>16,17</sup>. Such low expectations may relate to the belief that incontinence is an inevitable aspect of ageing as well as a lack of information about treatment options<sup>18-20</sup>. Low expectations may be reinforced by staff who often lack knowledge about active approaches to continence diagnosis and treatment<sup>21-28</sup>.

Moreover, people often feel uncomfortable and embarrassed to talk about incontinence and hence remain silent. These factors should be considered when evaluating and reporting satisfaction with continence care.

Another key finding was the tendency for assessors to rely on documentation about care processes to evaluate the quality of continence care. Research has shown that there is a mismatch between documented continence care and care that a resident actually receives. For example, research from the USA suggests that residents receive considerably less toileting assistance than is documented in their care plans<sup>13-16</sup>. It may be possible for facilities to develop care plans that document residents' continence care needs to meet Accreditation Standard 2.12, even if such plans are not implemented in practice.

Recent initiatives designed to strengthen the accreditation process and minimise inconsistent evaluation and reporting processes include a draft set of revised Accreditation Standards. The proposed new continence care standard advocates continence promotion and the maintenance of continence where possible. Staff will need to demonstrate that they manage the condition, and monitor and respond to residents' needs in a way that promotes an individual's privacy and dignity<sup>29</sup>. This revised standard may help shift the language about care to incorporate terms like privacy and dignity; however, questions about measuring such concepts persist.

Another initiative is the development of indicators to evaluate the quality of care in RACF<sup>30-35</sup>. However, researchers and policy makers have yet to reach consensus about the best indicators of quality continence care. The ICI recommendations<sup>7</sup> for managing incontinence in frail, older people may be a useful starting point from which to develop quality indicators for continence care in RACF. It may also be useful to link these quality indicators to evidence-based approaches to continence assessment and management in RACF. The Continence Tools for Residential Aged Care<sup>36</sup> provide a standardised and evidence-based method for assessing and managing incontinence in Australian RACF. The tools guide clinical care, meet accreditation standards and administrative purposes and could be used by assessors to evaluate continence care on the basis of structure, process and outcomes with reference to the perspectives of residents and their representatives.

## Limitations

The current study analysed descriptive data to identify how assessors determine and document the quality of continence care, and compared documentation with the ICI recommendations<sup>7</sup>. It relied on secondary documentation sources. The absence of documentation about quality care in accreditation reports may

not equate to a lack of quality care. Moreover, the analysis was based on text data related to Accreditation Standard 2.12 and did not include analyses of other care standards. It is possible that other factors that should be included in a continence assessment were evaluated with reference to other standards. However, a comprehensive approach to evaluating the quality of continence care in RACF should include information about all factors that affect an individual's continence care under Standard 2.12.

## Conclusion

Quality of care in RACF in Australia is evaluated with reference to the Aged Care Accreditation Standards. However, it was not clear how these standards were used to evaluate continence care. The current study indicated that many of the factors recommended by the peak international agency on incontinence were not addressed in accreditation reports. The lack of documentation about assessment processes to identify potentially treatable causes, and a lack of information on outcomes, suggests that the accreditation process may inadvertently endorse passive continence care rather than active diagnosis and management. Arguably, the evaluation of the quality of continence care in the residential aged care sector should be guided by ICI recommendations<sup>7</sup> and by the perspectives given by residents and their representatives. Guidelines or quality indicators should be developed to strengthen continence care and evaluation processes in Australian RACF.

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