

DOES GOOD ORGANISATIONAL STRUCTURE LEAD TO QUALITY CARE PROVISION FOR OLDER PEOPLE WITH INCONTINENCE?

Hypothesis / aims of study

There is a paucity of effort to monitor the implementation of evidence based guidelines and their outcome but in the National Health Service in England and Wales, a clinical audit and research programme has been established to survey the effectiveness of care for a variety of conditions. The National Audit of Continence Care for Older People [1] has reported wide variability in the standard of care for older people with urinary and faecal incontinence and upon the considerable differences in how care is provided, despite national guidelines on service provision. Systematic collection of clinical outcome data however, remains the most difficult task in the measurement of clinical effectiveness, often due to limitation on resources for longitudinal follow up of surveyed cohorts. Examination of the relationship between organisational structure i.e. the personnel, skills resources and knowledge available to care for people and clinical process of care (what is actually done for people) may provide a surrogate measure of quality in care. A better quality of care should lead to an improved outcome for patients. This study used data from the National Audit of Continence Care for Older People to examine whether there was such an association between organisational structure and standard of continence care for continence services for older people in the community, in hospitals and in care homes in England and Wales.

Study design, materials and methods

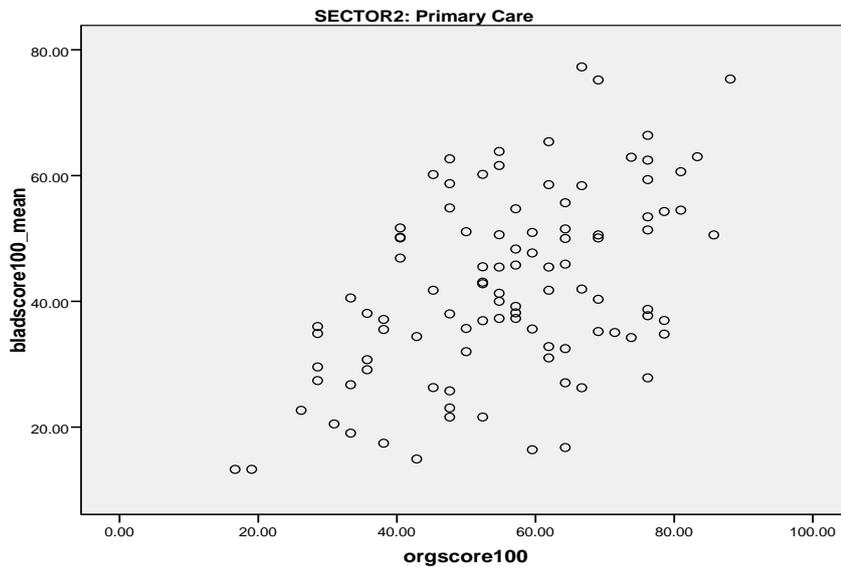
Standards for measuring quality of care were derived from pre-existing work and government publications, and then further developed by a multidisciplinary steering group and a wide range of professionals with expertise within the continence field. The resulting package was piloted and modified prior to the National Audit. Each participating site returned data on the facilities and organisation for care of continence received by their patients and also returned data on the care of 20 patients aged 65 years and over with urinary incontinence (UI) and 15 with faecal incontinence (FI) as defined by the clinical record. Data were based upon a cross sectional retrospective audit of consecutively admitted patients to hospitals; consecutive patients identified in a single General Practice in primary care and consecutive residents identified in care homes. Data were submitted via the Internet to a secure web site, and anonymity was maintained for all data. Organisational data were then scored in a binary fashion (factor present / absent) to produce a score which was then normalised out of 100. A score for process of care data was similarly developed and the relationship between the two examined. The bladder and bowel scoring systems were applied at the patient level and then for each site the mean bladder and bowel score were computed. The relationship between the quality of bladder and bowel care by each organisation was similarly compared. Statistical analysis was by Spearman's test.

No patient contact was required for the conduct of the audit. Advice from ethical committees was that permission was not required for this work because as no intervention was involved. Data transfer was in accordance with standards of practice laid out by the Patient Information Advisory Group in the UK.

Results

Scores from 101 primary care (PC), 173 hospital (H) and 83 care homes (CH) were calculated and compared. Each had a site average toward the centre of the scale with no evidence of clustering at 0 or 100. Quality of care scores were derived from data returned on 3385 community dwelling, 6822 hospitalised and 2745 institutionalised older people. Data for each site are shown in the table and in graphical form for primary care for UI.

SPEARMAN CORRELATION	Organisational bladder	with	Organisational bowel	with	Bladder with bowel
ALL sites	0.31, p<0.001		0.31, p<0.001		0.78, p<0.001
By Sector:					
Primary care	0.44, p<0.001		0.49, p<0.001		0.81, p<0.001
Acute Hospitals	0.26, p=0.001		0.30, p<0.001		0.83, p<0.001
Care Homes	0.32, p=0.004		0.26, p=0.02		0.73, p<0.001



Interpretation of results

Using a simple score, a relationship between organisational strength and clinical care exists for continence care. Health care providers with an integrated service [2] appear to provide higher quality care to older people. These relationships are there for each sector though the correlation between organisation and care of bladder/bowel problem scores is strongest for primary care. Similar results have been shown in stroke and cardiac conditions [3]. The provision of high quality care for continence appears to be dependent upon well organised services with personnel who have the appropriate training and skills to deliver the care.

Concluding message

Organisational culture is paramount in the provision of quality continence care for older people.

References

1. Age Ageing. 2008;37(1):39-44
2. Good Practice in Continence Services. Department of Health.2000. HMSO London
3. Crit Pathw Cardiol. 2007 Dec;6(4):145-9

<i>Specify source of funding or grant</i>	Healthcare Commission UK
<i>Is this a clinical trial?</i>	No
<i>What were the subjects in the study?</i>	HUMAN
<i>Was this study approved by an ethics committee?</i>	No
<i>This study did not require ethics committee approval because</i>	No patient contact was required as part of this study. Ethical committee advice taken
<i>Was the Declaration of Helsinki followed?</i>	No
<i>This study did not follow the Declaration of Helsinki in the sense that</i>	No patient contact was required and thus no consent was gained
<i>Was informed consent obtained from the patients?</i>	No