

Hospital-Acquired Complication **12**

PERSISTENT INCONTINENCE

	HOSPITAL-ACQUIRED COMPLICATION	RATE ^a
1	Pressure injury	10
2	Falls resulting in fracture or intracranial injury	4
3	Healthcare-associated infections	135
4	Surgical complications requiring unplanned return to theatre	20
5	Unplanned intensive care unit admission	na ^b
6	Respiratory complications	24
7	Venous thromboembolism	8
8	Renal Failure	2
9	Gastrointestinal bleeding	14
10	Medication complications	30
11	Delirium	51
12	Persistent incontinence	8
13	Malnutrition	12
14	Cardiac complications	69
15	Third and fourth degree perineal laceration during delivery (per 10,000 vaginal births)	358
16	Neonatal birth trauma (per 10,000 births)	49

a per 10,000 hospitalisations except where indicated
b na = national data not available

Persistent incontinence is defined as urinary incontinence that arises during a hospital admission, and which is present on discharge or which persists for seven days or more.*



Why focus on persistent incontinence?

Each year, patients in Australia experience more than 3,690 episodes of persistent incontinence.¹

Persistent urinary incontinence has a significant impact both on those who suffer from it, as well as on people caring for those with the condition.² Patients’ experiences range from inconvenience to social and psychological stigmatisation, and include physical symptoms such as skin irritation and painful excoriation.

There are many causes of persistent urinary incontinence.² While the majority of the factors are associated with natural life circumstances (such as childbirth and menopause) and underlying systemic conditions (such as diabetes, obesity, cardiovascular, multiple sclerosis), there are additional factors which can create or worsen incontinence conditions.^{3,4} Many of these factors may arise in the context of hospital-related care, such as postoperative complications following prostate surgery or hysterectomy, constipation, medications (such as antidepressants, oestrogens, diuretics, and sleep medications), infections such as a urinary tract infection, and poor mobility due to surgery for another condition (such as fractured neck of femur).^{3,4}

The rate of hospital-acquired persistent incontinence in Australian hospitals was 8.3 per 10,000 hospitalisations in 2015–16.¹ Hospital-acquired persistent incontinence prolongs length of hospitalisation, which impacts on patients and their families. Hospital-acquired persistent incontinence also increases the cost of admission incurred by the health service. This additional cost may be the result of an increased length of stay or more complex care requirements.⁵ While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient.

* The specifications for the hospital-acquired complications list providing the codes, inclusions and exclusions required to calculate rates is available on the [Commission’s website](#).

The majority of persistent incontinence can be prevented. Significant reductions in persistent incontinence rates are being achieved in some hospitals by preventive initiatives. The rate of persistent incontinence at Principal Referral Hospitals* was 9.3 per 10,000 hospitalisations. If all Principal Referral Hospitals above this rate reduced their rate to 9.3 per 10,000 hospitalisations, then 838 episodes of persistent incontinence during hospitalisation in these hospitals would have been prevented, and more when other facilities are considered.

* Hospitals were classified in the Principal Referral Hospitals peer group for these purposes according to the Australian Institute of Health and Welfare's former definition of major city hospitals with more than 20,000 acute weighted separations and regional hospitals with more than 16,000 acute weighted separations.



What is considered best practice for preventing persistent incontinence?

All hospital-acquired complications can be reduced (but not necessarily eliminated) by the provision of patient care that mitigates avoidable risks to patients.



The **health service organisation** providing services to patients at risk of persistent incontinence:

- Has systems for incontinence prevention and management that are consistent with best-practice guidelines
- Ensures that equipment and devices are available to decrease the risk and effectively manage incontinence.



Clinicians caring for patients at risk of persistent incontinence:

- Conduct comprehensive continence assessments in accordance with best-practice time frames and frequency
- Provide incontinence prevention and care in accordance with best-practice guidelines.



The National Safety and Quality Health Service (NSQHS) Standards (second edition), in particular the Comprehensive Care Standard⁶, support the delivery of safe patient care.

The advice contained in the hospital-acquired complication fact sheets aligns with the criteria in this standard, which are as follows:

- Clinical governance structures and quality-improvement processes supporting patient care
- Developing the comprehensive care plan
- Delivering the comprehensive care plan
- Minimising specific patient harms.

Top tips for prevention and management of persistent incontinence

The following provides key points for clinicians to consider to avoid this hospital-acquired complication

Conduct risk assessment

Conduct a comprehensive risk assessment

Identify risk factors such as:

- Medicines, such as antidepressants, oestrogens, diuretics and sleep medicines
- Underlying systemic conditions such as diabetes, obesity, cardiovascular, multiple sclerosis
- Infections, such as urinary tract infection
- Postoperative complications following prostate surgery or hysterectomy
- Constipation
- Poor mobility due to surgery, such as fractured neck of femur
- Childbirth
- Menopause

Review other factors such as delirium, polyuria including that from heart failure or hyperglycaemia, faecal impaction, urinary retention, bladder issues and/or toilet access or signage.

For a patient at risk, develop a prevention plan as part of a comprehensive care plan

Develop prevention plan

Clinicians, patients and carers develop an individualised, comprehensive prevention plan to prevent incontinence that identifies:

- Goals of treatment consistent with the patient's values
- Any specific nursing requirements, including equipment needs
- Any allied health interventions required, including equipment needs
- Observations or physical signs to monitor and determine frequency of monitoring
- Laboratory results to monitor and determine frequency of monitoring
- If specialist assistance is required.

Deliver prevention plan

Where clinically indicated, deliver incontinence prevention strategies, such as:

- Identify and treat reversible causes of incontinence
- Consider carefully the need to insert an indwelling catheter, and aim for earliest safe removal.

Monitor

- Monitor the effectiveness of incontinence prevention strategies, and reassess the patient if persistent incontinence occurs
- Review and update the care plan if it is not effective or is causing side effects
- Engage in reviewing clinical outcomes, identifying gaps and opportunities for improvement.



Clinical governance structures and quality-improvement processes

to support best practice in incontinence prevention and management

Health service organisations need to ensure systems are in place to prevent incontinence through effective clinical governance and quality improvement.

The NSQHS Standards (2nd ed.) describe actions that are relevant to the prevention and management strategies outlined below. These actions are identified in brackets.

Policies, procedures and protocols

Health service organisations ensure policies, procedures and protocols are consistent with national evidence-based guidelines for the risk assessment, prophylaxis and management of incontinence. **(1.27, 5.1a)**

Best-practice screening and management

Health service organisations:

- Agree on the process and criteria for incontinence risk screening **(5.7)**
- Inform the clinical workforce of screening requirements **(5.1c)**
- Identify a format for continence assessments **(5.4)**
- Identify a format for prevention plans for high-risk patients **(5.4)**

Identify a management plan format for patients with incontinence. **(5.12, 5.13)**

Identification of key individuals/governance groups

Health service organisations identify an individual or a governance group that is responsible for:

- Monitoring compliance with the organisation's continence policies, procedures and protocols **(1.7b, 5.2a)**
- Presenting data on the performance of incontinence prevention and management systems to the governing body **(1.9, 5.2c)**

Overseeing the care of patients at risk of persistent incontinence. **(5.5b)**

Training requirements

Health service organisations:

- Identify workforce training requirements **(1.20a)**
- Train relevant staff on the use of risk screening, prevention plans and incontinence management plans **(1.20b, 1.20c)**

Ensure workforce proficiency is maintained. **(1.20d, 1.22, 1.28b)**

**Monitoring
the delivery of
prophylaxis and care**

Health service organisations ensure mechanisms are in place to:

- Report incontinence **(1.9, 5.2)**
- Manage risks associated with incontinence prophylaxis and management **(5.1b)**
- Identify performance measures and the format and frequency of reporting **(1.8a)**
- Set performance measurement goals **(1.8a)**
- Collect data on compliance with policies **(1.7b)**
- Collect data about incontinence risk screening activities, including whether risk assessment is leading to appropriate action **(1.8, 5.1b, 5.2)**
- Identify gaps in systems for screening patients for incontinence collect data on incidence, prevalence and severity of incontinence **(5.2)**
- Provide timely feedback and outcomes data to staff. **(1.9)**

**Quality-
improvement
activities**

Health service organisations:

- Implement and evaluate quality-improvement strategies to reduce the frequency and harm from incontinence **(5.2)**
- Use audits of patient clinical records and other data to:
 - identify opportunities for improving incontinence prevention plans **(5.2)**
 - identify gaps and opportunities to improve the use of incontinence prevention plans (such as increasing the number of at-risk patients who have incontinence prevention plans implemented) **(5.2)**
 - monitor the overall effectiveness of systems for prevention and management of incontinence. **(5.2)**
- Use audits of patient clinical records, transfer and discharge documentation and other data to:
 - identify opportunities for improving incontinence management plans **(5.2)**
 - assess compliance with incontinence management plan requirements **(5.2)**
 - identify strategies to improve the use and effectiveness of incontinence management plans. **(5.2)**

**Equipment
and devices**

Health service organisations facilitate access to equipment and devices for the prevention and management of incontinence. **(1.29b)**



Developing the patient's comprehensive care plan

to support best practice in persistent incontinence prevention and management

Clinicians should collaborate with patients, carers and families in assessing risk, in providing appropriate information to support shared decision making, and in planning care that meets the needs of patients and their carers.

Identifying risk factors for incontinence

Clinicians identify risk factors associated with persistent incontinence which include^{3,4}:

- Medicines, such as antidepressants, oestrogens, diuretics and sleep medicines
- Underlying systemic conditions such as diabetes, obesity, cardiovascular, multiple sclerosis
- Infections, such as urinary tract infection
- Postoperative complications following prostate surgery or hysterectomy
- Constipation
- Poor mobility due to surgery, such as fractured neck of femur
- Childbirth
- Menopause.

Implement risk assessment screening

Clinicians use relevant screening processes at presentation to assess the risk of incontinence and requirements for prevention strategies.

Clinical assessment

Clinicians comprehensively assess:

- Conditions, including reversible causes:
 - delirium
 - dementia
 - urinary tract infection
 - atrophic urethritis and vaginitis
 - depression
 - polyuria such as from heart failure or hyperglycaemia
 - restricted mobility
 - faecal impaction.

Clinicians should also monitor for:

- Decreased fluid intake
- Urinary retention
- Lack of toilet access/poor signage
- Whether the patient is completely emptying their bladder, especially if they have a neurological condition
- Medicines
- Risks identified through screening process.

Clinicians undertake comprehensive clinical assessment and document in the clinical record.

Informing patients with a high risk

Clinicians provide information for patients with high risk and their carers about incontinence prevention and management.

Planning in partnership with patients and carers

Clinicians inform patients, family and carers about the purpose and process of developing an incontinence management plan and invite them to be involved in its development.

Collaboration and working as a team

Medical, nursing, pharmacy and allied health staff work collaboratively to perform incontinence risk assessment and clinical assessment.

Documenting and communicating the care plan

Clinicians document in the clinical record and communicate:

- The findings of the risk screening process
 - The findings of the clinical assessment process
 - The incontinence prevention plan
 - If needed, a continence chart can be implemented.
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Delivering comprehensive care to prevent and manage persistent incontinence

Safe care is delivered when the individualised care plan, that has been developed in partnership with patients, carers and family, is followed.

Collaboration and working as a team

Medical, nursing, pharmacy staff and allied health workers collaborate to deliver incontinence prevention and management.

Delivering incontinence prevention strategies in partnership with patients and carers

Clinicians work in partnership with patients and carers to use the comprehensive care plan to deliver incontinence prevention strategies where clinically indicated, for example by:

- Identifying and treating reversible causes of incontinence
 - Considering carefully the need to insert an indwelling catheter, and aiming for earliest safe removal
 - Offering regular toileting opportunities and prompts.
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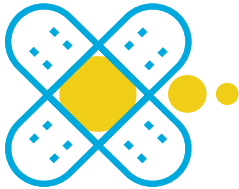
Delivering incontinence management in partnership

Clinicians work in partnership with patients and carers to ensure patients who have incontinence are managed according to best-practice guidelines.

Monitoring and improving care

Clinicians:

- Monitor the effectiveness of these strategies in preventing incontinence and reassess the patient if incontinence occurs
- Review and update the care plan if it is not effective or is causing side effects
- Engage in reviewing clinical outcomes, identifying gaps and opportunities for improvement.

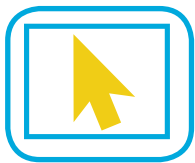


Minimising specific patient harm

Patients at risk of specific harms are identified, and clinicians deliver targeted strategies to prevent and manage these harms.

Nutrition and hydration

Ensure the nutritional and fluid requirements of the patient are planned, delivered and adjusted as appropriate, and that the patient's intake and output are monitored.



Additional resources

Continence Foundation of Australia. [Key statistics](#). [Melbourne](#).

Agency for Healthcare Research and Quality. [Toolkit for Reducing CAUTI in Hospitals](#). [Rockville, MD \(US\) Agency for Healthcare Research and Quality; 2017 \[updated March 2017\]](#).

National Institute for Health and Care Excellence. [Urinary incontinence in women: management, Clinical guideline \[CG171\]](#). [UK 2013, Updated 2015](#).

Queensland Health. [Continence clinical guidelines and resources](#). [Brisbane \(AU\)](#).

Joanna Briggs Institute. Educational interventions to raise men's awareness of bladder and bowel health. *Nursing & Health Sciences*. 2013;15(1):131–3

Qaseem A, Dallas P, Forcica M, et al. [Nonsurgical management of urinary incontinence in women: A clinical practice guideline from the American College of Physicians](#). [Annals of Internal Medicine](#). 2014; 161(6):[429–40 pp.].

Note on data

The data used in this sheet are for hospital-acquired complications recorded during episodes of care in Australian public hospitals in 2015–16. Data are included where hospitals were able to identify that the complication had arisen during an admission using the condition onset flag. Figures reported by the Independent Hospitals Pricing Authority (IHPA) may differ due to the IHPA's methodology, which applies different inclusion/exclusion criteria.

References

1. Independent Hospital Pricing Authority (AU). Activity Based Funding Admitted Patient Care 2015–16, acute admitted episodes, excluding same day.
2. Australian Institute of Health and Welfare. Incontinence in Australia: prevalence, experience and cost 2009. Canberra: AIHW; 2012.
3. Continence Foundation of Australia. Who's at risk? Melbourne (AU) Available from: <https://www.continence.org.au/pages/whos-at-risk.html>.
4. Palmer MH, Baumgarten M, Langenberg P, Carson JL. Risk factors for hospital-acquired incontinence in elderly female hip fracture patients. *The journals of Gerontology Series A, Biological sciences and medical sciences*. September 2002 ed2002. p. 672–7.
5. Independent Hospital Pricing Authority, Pricing and funding for safety and quality – Risk adjustment model for hospital acquired complications – version 3, March 2018, IHPA: Sydney.
6. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards (second edition). Sydney 2017.

AUSTRALIAN COMMISSION
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