Working with families to boost children’s continence

In this article...

A new care model for promoting children’s continence
Working with families to educate and empower
A discussion of service provision for children

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This article discusses a new care model for managing idiopathic paediatric continence problems. A key aspect of the innovation is empowering the child and family to self-manage the problem. This resulted in improved treatment outcomes and reduced both “did not attend” rates and waiting lists. It was also cost effective.

In 2005 I was seconded for two days per week from PromoCon to a community-based continence service with a remit to set up and develop an integrated children’s continence service. Previously no specific continence service for children had existed within the community so it was an ideal opportunity to look at service provision in a new way.

In 2004 the National Service Framework (NSF) for children acknowledged there were “big gaps in service provision for children with continence problems, which lead to inappropriate referrals and wasted resources” (Department of Heath, 2004).

The purpose of our initiative was to develop a family centred model of care that would lead to an improved service for children with idiopathic continence problems, such as delayed toilet training, bedwetting and constipation. These conditions generally do not require intensive investigations and respond well to nurse-led standard treatment therapy. This new model of care was developed and trialled within the primary care trust. It aimed to reduce long waiting lists and high “did not attend” (DNA) rates.

There was also some evidence of relatively poor treatment outcomes resulting in inappropriate referrals to acute care, so it was important to improve the quality of care. The service was developed within existing budgets so it also had to be cost effective. Symptom assessment tools have been shown to improve clinical decision making and optimise treatment outcomes. It was, therefore, important to develop standardised assessment tools.

The three-part model

Traditional treatment approaches involve the nurse directing the intervention, with the child and family often taking a passive role. This approach runs the risk of failure due to the family’s lack of understanding and commitment or non-compliance. The new three-part model of care involves children, families and health professionals all having equal responsibilities:

» The nurse takes responsibility for assessment, education and support;
» The parent(s) take responsibility for carrying out the agreed intervention in partnership with the child;
» The child (age appropriately) takes ownership of the problem while being able to externalise the underlying cause (no blame approach).

The initiative required a change in working methods and also a change in practice to reflect up-to-date evidenced-based treatments, including the National Institute for Health and Clinical Excellence (2003a) guidelines on nocturnal enuresis and idiopathic constipation in childhood.

Assessment and follow-up

Previously children were seen in the clinic for an initial assessment and instigation of treatment. The parent takes responsibility for carrying out the intervention.
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treatment before being invited back for review. This has resulted in several problems, including high DNA and relapse rates as well as long waiting lists.

With the new model of care the child and family are given only one face-to-face appointment and all other follow-ups are done via the telephone. When the model was introduced, on receiving a new referral the nurse phoned the family and arranged a mutually agreeable appointment. At this appointment, following assessment, time was spent giving the child and family advice and information regarding the problem and the treatment options available. This enabled informed choices to be made and encouraged self/family management of the problem within an agreed set of parameters.

A “grey area” was around toilet training and the provision of continence products such as nappies. A blanket policy of providing free nappies is no longer appropriate. Historically once children reached a certain age and had an underlying condition they automatically became eligible for the provision of products. But this involved no more than a paper exercise with most children not having continence promoted or their underlying problems identified.

In response, we developed a number of symptom-assessment tools to help nurses with decision-making and to help standardise practice. Previously the responsibility for product provision was within the remit of health visitors, however, it was clear that without the appropriate training and the lack of opportunity to develop specific expertise, the product provision was not standardised across the trust.

In order to address this, the author took overall responsibility for assessment and issuing of products for all new referrals until the health visitor had received the appropriate training. However, it quickly became apparent that with just one person responsible for assessment and product provision, practice soon became standardised and the inappropriate supply of products was eliminated.

Of the children referred to the PCT for delayed toilet training and a request for free nappies, most were in fact able to complete toilet training pathways and, over the following five years, the number of children in receipt of products dropped from more than 700 to less than 300.

Setting up similar initiatives

This model of care is easily transferable and makes use of existing resources in an effective way. Advice for others would be to first of all map out the journey for a child with a continence problem to identify current practice. This will reveal where and how their journey can be shortened and treatment outcomes improved. Points to consider include:

- Where are the children currently being seen and by whom?
- Do the health professionals undertaking the assessment have appropriate training?
- What documentation is being used and does it incorporate evidenced-based practice such as NICE recommendations on constipation and bedwetting (NICE 2010a, 2010b)?

If numerous different health professionals are assessing the children, it is likely to result in disparity and poor outcomes, particularly if they have had no specific training. It is important to identify a key person to take overall responsibility for the provision of continence care for children and cascade down good practice.

Benefits of the initiative

This three-part model of care gives ownership of the continence problems back to the child and family. In the past many families expected the nurse to “fix” the problem without the families themselves having to do much about it. Successful treatment outcomes depend on the child and family following the advice given. For example, if the toileting and other treatment programmes are not carried out at home, it means that the risk of treatment failure is high.

With the new model of care, the child and family are able to develop a good understanding of the child’s problems and so informed choices can be made regarding the best treatment option. This has led to better compliance with improved treatment outcomes. Patient satisfaction is high with DNA rates drastically reduced.

Under the new model, the involvement of health professionals is kept to a minimum, which means that nurses can see new referrals more quickly. This has reduced the waiting list and freed up nurses’ time. The symptom-assessment tools help to standardise practice and improve treatment outcomes. The implementation of evidenced-based practice has reduced, and in some cases eliminated, inappropriate referrals to acute care.

A cost-effective initiative

The new model of care has resulted in considerable cost savings via several routes:

- By following evidenced-based practice, treatment times have been shortened;
- The symptom-assessment tools led to most children being offered toilet training programmes rather than products;
- The mutually agreeable clinic appointment/daytime has reduced DNA rate to less than 1.4%;
- Elimination of acute care referral for children with idiopathic constipation could potentially save more than £250,000 per year.

Implications for practice

This model requires minimal input from health professionals. It tackled the issue of waiting lists, reduced the DNA to less than 1.4%, while greatly reducing referrals to acute care.

The model is also relevant to nursing practice elsewhere and could be used not only within continence promotion for both adults and children, but also in any area where the child and family are responsible for the day-to-day management of the condition, such as diabetes or asthma.

The initiative fits within the Quality, Innovation, Productivity and Prevention (QIPP) agenda, which is about making services as efficient as possible and making sure patients have the best care possible. It also has relevance to key publications, including Cost Effective Commissioning for Continence Care (All Party Parliamentary Group for Continence Care, 2011) and Paediatric Continence Services – Commissioning Guide (NICE, 2010c) among many others.

The Any Qualified Provider (DH, 2011) initiative sets out a framework for best practice, including the provision of paediatric continence care within the wider service remit. This model of care will enable such development, particularly in areas where previously specific continence services for children and young people did not exist. NT

References


