



**Health**

Hunter New England  
Local Health District

Fixing a wee problem – Will the SCAMP  
(Structured urinary Continence Assessment and  
Management Plan) intervention make a  
difference? – Study Protocol (and baseline  
results to date)

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@SMARTSTROKES19 @Kerry\_StrokeRN #SMARTSTROKES19



# Urinary Incontinence Is Common



- Negative effects for patients, carers and health systems
- Stroke Foundation Audit → 35% acute stroke patients and 41% post-stroke rehabilitation patients
- Only half of these patients have documented management plans





- Often taboo subject related to:
  - falls
  - altered mood
  - disability
  - complications (eg UTIs, skin break down)
  - major reason for RACF placement



- 8 Recommendations for Urinary Incontinence
- Translating the recommendations into routine practice → Challenging!





## Research Question

Will broader implementation of our previously piloted SCAMP intervention improve urinary incontinence assessment and management for in-hospital patients following stroke?

## Aim

Improve assessment, diagnosis & management of urinary incontinence for inpatients of acute stroke/ medical, or on a rehabilitation unit.

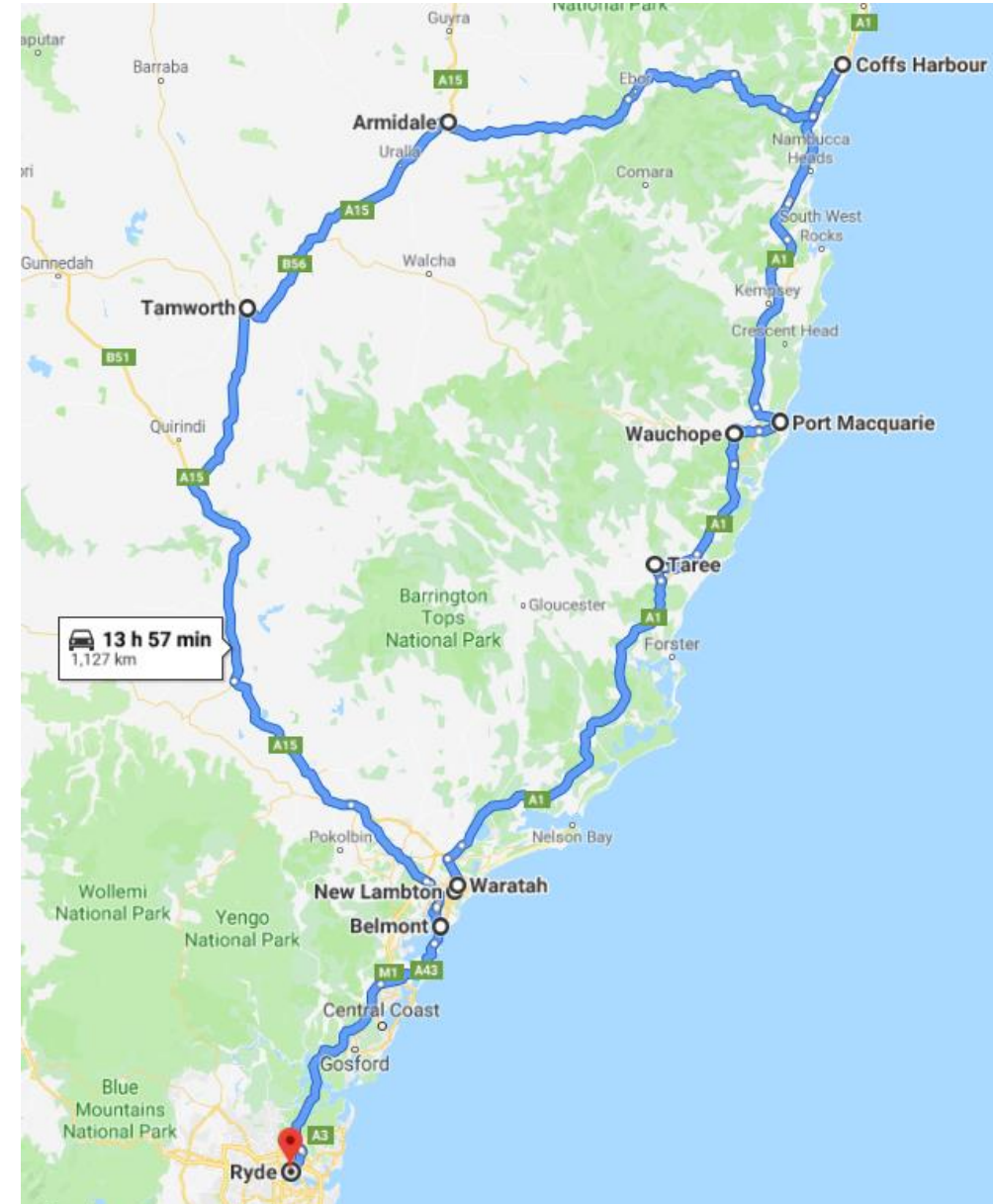


# I-SCAMP Protocol - Method



- **Setting:** 15 inpatient wards → 3 LHDs  
→ NSW, Australia

Figure 1 – Map showing participating sites





**Design:** Pragmatic, non-controlled, before- and after-implementation study using mixed methods

**Target group:** Clinicians working on the participating wards





- **Primary Outcome:**
- The change in the proportion of incontinent patients who have a continence management plan





# I-SCAMP Protocol - Outcomes



- **Secondary:**
  - Change in patients who have
    - Contenance assessment
    - Incontinence diagnosis
    - Patient/carer involvement in development of individualised continence management plans
    - complications
  - change clinician perceptions → skills, knowledge, confidence
  - Economic impact



# I-SCAMP Protocol - Method



- **Intervention:**
- SCAMP tools & processes
- Education
- Audit and feedback
- Champions

We are happy to share this work with other health services but please acknowledge by including on your form - Developed by Hunter Stroke Service, Hunter New England Local Health District

PLEASE USE DOUBLE LABEL IF AVAILABLE

SURNAME: \_\_\_\_\_

OTHER NAMES: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ M.O. \_\_\_\_\_

HOSPITAL / WARD: \_\_\_\_\_

Facility: \_\_\_\_\_

**STRUCTURED CONTINENCE ASSESSMENT & MANAGEMENT PLAN**

**Urinalysis**

- Attended Yes  No
- Abnormalities reported to medical officer Yes  No  N/A
- Culture if infection suspected e.g. urine positive for nitrites, leukocytes or blood, and symptoms of dysuria Yes  No  N/A

**Post void residual volume (PVRV)**

- PVRV bladder scan first 72 hours as a screen for urinary retention. Yes after each void  Yes random daily post void  No  N/A reason: \_\_\_\_\_

**Is patient continent of urine?**

Yes  -- monitor continence status, including TDS PVRV for 72 hours (as above)  
 No  -- continue continence assessment and complete management plan

**Urinary catheter**

- Urinary catheter: in situ Yes  No  urethral  suprapubic
- Catheter intermittent: Yes  No  Frequency \_\_\_\_\_
- Reason for insertion / Retention: Yes  No  Other: \_\_\_\_\_
- Catheter inserted prior to admission Yes  No  Date: \_\_\_\_\_
- Expected date of removal of catheter: \_\_\_\_\_

**Medical history**

- Diabetes  Previous stroke  Back pain/injury  Spinal cord injury
- Multiple Sclerosis  Parkinson's Disease  Cancer urinary tract  Cystitis  Obesity
- Chronic cough  Urinary tract infection in last 12 months  Enlarged prostate
- Chronic constipation  Other: \_\_\_\_\_

**Surgical history**

- Hysterectomy  Bladder surgery  Pelvic surgery  Prostate surgery
- Other: \_\_\_\_\_

**Medication review**

- Request medical officer or pharmacist to review medications that may interfere with bladder or bowel function Yes  No  N/A

**Urinary incontinence (UI) prior to admission**

- History of UI Yes  No
- Urinary incontinence type (if known) \_\_\_\_\_
- Duration < 6 months  \_\_\_\_\_ Years Lifelong
- Incontinence pad use Daytime  Night time  Both  N/A

**Hydration**

- Ensure fluid intake = 2000 mL/day unless contraindicated. Yes  No  N/A
- If urine specific gravity > 1030 the patient may be dehydrated. Increase fluids if not contraindicated. Yes  No  N/A

**Renal function**

- Refer to medical officer if history of renal disease Yes  No  N/A

**Bowel assessment**

- Bowel assessment form completed Yes  No
- Does patient have faecal incontinence? Yes  No  Unsure

**Abdominal assessment**

- Palpable bladder Yes  No  Unsure
- Palpable abdominal mass Yes  No  Unsure

**Perineal assessment**

- Healthy  Dry, thin mucosa  Prolapse  Vaginitis  Other: \_\_\_\_\_
- Refer to medical officer if abnormality detected Yes  No

**Cognition / communication**

- Poor cognition Yes  No  Unsure  Dementia Yes  No  Communication difficulties Yes  No  Unsure

**Dexterity**

- Independent  Needs assistance

**Current mobility**

- Independent  Walks with assistance  Walks with aids  Chair bound
- Falls Risk \_\_\_\_\_ Waterlow score \_\_\_\_\_

Date: \_\_\_\_\_ Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Designation: \_\_\_\_\_





- **Data collection:**
- Medical Record Audit
- Clinician Questionnaire
- Barrier Identification and Mitigation Tool
- 3 time points
  - Before implementation
  - after implementation
  - maintenance/ sustainability



- Ethics is approved.
- Before-implementation data collection → January 2019.
- Planned project completion - End 2021





- 262 respondents → predominantly female (82%)
- Mixed clinical experience →
  - 0-1yrs=14%,
  - 1-10 years=44%
  - >10yrs=42%





- On  $\geq$  “some days of your working week” were involved in UI
  - assessment (78%)
  - diagnosis (61%) or
  - management (90%)



- Key enablers → “Beliefs about Consequences” and “Goals” domains.
- Key barriers → “Environmental Context and Resources”, “Knowledge” and “Skills” domains



- 680 medical records audited to date
  - females= 365 (54%)
  - mean(SD) age = 76 (15) years (all audited)
  - mean(SD) age = 73 (15) years (continent)
  - mean(SD) age = 80 (13) years (incontinent)







- 87% continence status → derived from progress notes
- 242 (35%) inpatients → urinary incontinence
  - 68/242 (28%) had an incontinence diagnosis
  - 19/242 (8%) had a management plan



- Reason for admission
  - Medical Diagnosis (33%)
  - Stroke and TIA (24%)
  - Falls (14%)
  - Fractures (8.3%)



- Substantial urinary continence evidence-practice gaps identified in inpatient settings.
- Successful implementation → harness the enablers and target the barriers.



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# Questions?

