Continence care in the elderly: whose role is it anyway?

This report is based on presentations given at the satellite symposium *Continence care in the elderly: whose role is it anyway?*, which took place at the 2011 Autumn meeting of the British Geriatrics Society, Brighton.

Alison Bloomer Editor, GM

Welcome and introduction

Adrian Wagg, Professor of Healthy Ageing, University of Alberta Edmonton, Alberta

The key questions that we need to ask to re-enthuse geriatricians are: why is incontinence largely ignored by geriatricians; what are the barriers to offering treatment; and what can be done to engage the geriatrician in looking after those patients with urinary incontinence (UI)?

In a recent paper called: "*To what extent are national guidelines for the management of urinary incontinence in women adhered? Data from a national audit,*" it was found that in both primary and secondary care older women are less likely to receive evidence-based management.[1] Why is this? There could be a barrier to patients seeking help as they see UI as an inevitable aspect of ageing and something to be accepted and managed independently, or even that they will not disclose it because of shame and embarrassment.

From a healthcare perspective, the barriers to patients receiving treatment include lack of awareness of treatments, poor knowledge base, a belief that current treatments are ineffective and that UI is a natural consequence of ageing. In many cases, GPs were reluctant to treat the UI and a physical examination did not take place in spite of GPs' conviction as to the benefit of it. Knowledge of the treatment options available to the older patient with UI is also substandard.

Like pressure ulcer care, continence care is seen by many as a nursing specialty. So would nurses do better? Although nurses from all clinical areas identify the importance of promoting continence, the problem continues to be contained rather than treated. Conflicting clinical priorities, varying staff approaches to UI and deficits in education are cited among the barriers to promoting continence.

For geriatricians in a recent Astellas survey, issues with polypharmacy, limited trial evidence in this age group and patient adherence to treatment regimen were top of the list of barriers to treatment as well as a lack of active interest in this area.

1. BJOG. 2011 Sep 6. doi: 10.1111/j.1471-0528.2011.03100.x

The basics of good continence care in the elderly

Dr Susie Orme, Consultant Geriatrician, Barnsley Hospital NHS Foundation Trust

The prevalence of UI increases with age and

Astellas sponsored this meeting report and the satellite symposium at the 2011 Autumn meeting of the British Geriatrics Society in Brighton and has reviewed this report solely to verify its factual accuracy

dependency. It is also an independent predictor of mortality and increases the risk of falling in the older age groups especially due to nocturia. This in turn adds to increased care-giver stress. Quality of life is also affected because of reduced social functioning, depression, debility, and long term care. So can treatment help?

There are many myths about incontinence in the elderly and these include the view that it is just part of the ageing process and that there is a lack of ability to practice evidence-based medicine as there is a paucity of scientific papers—although this is getting better. There is also a belief that the drugs don't work when they do and that they make the patient confused and fall over when they don't.

It is important to remember that no "one size fits all" in this group as multiple organ pathology is usual and bladder dysfunction can be one element of a larger picture. That is why geriatricians are ideally suited to manage these UI patients because complexity is our speciality as is multiple pathology and frailty. Personal considerations of treating this age group include social continence, less falls, more sleep, better quality of life and less care needs as well as less care-giver stress.

It does makes a big difference to our patients to treat their incontinence. We need to remember though that standard assessments do not reflect complex processes involved in social continence and that lower urinary tract (LUT) symptoms don't always come from LUT. Also realistic LUTS assessment involves observation of functional status. In addition, any treatment plan or investigation in the frail needs to be interpreted in the context of cognition, physical frailty and their environment.

Model 1: The Geriatrician working within an integrated continence service

Dr Eileen Burns, Consultant Geriatrician and Community Consultant Geriatrician, Leeds Teaching Hospitals NHS Trust

The integrated continence service came about after recognition by clinicians working in medicine for the elderly that there was a gap in service provision. Urology and urogynaecology were providing an excellent service for fitter patients with a single problem but complex, frailer patients on multiple medications and several comorbidities were missing out.

It has since evolved with the addition of a specialist continence promotion nurse within the acute trust and the PCT has developed local specialist teams and appointed a head of the bladder and bowel healthcare team.

Often frail older patients will have concomitant bladder and bowel problems, and both in hospital and in the community the commonest response (if the problem was even disclosed) was to provide pads.

We now have a team of six specialist nurses working in the community, there is education of district nurses, intermediate care teams and we hold clinics in local health centres (for all ages) advising on management of continence problems (bladder and bowel).

Our clinic is held in a day hospital at a peripheral secondary care site and referrals come from district or practice nurses, intermediate care teams, specialist continence nurses, GPs, geriatricians and (in theory but not practice) patients and carers. We link with urogynaecology and urology and cross refer. They provide access to urodynamics (beyond frequency/volume bladder dairies, flow rates and bladder volume scans) and they refer to us their frailer older patients who are on multiple medications/comorbidities. We refer men who are fit for and wish to consider prostate surgery and ladies who have symptoms of stress incontinence and who are fit for and wish to consider trans-vaginal tape (TVT) or other less invasive procedures, and occasionally we refer patients with severe OAB symptoms for botox when other measures have failed.

We also have links with the falls team and we refer patients both to the community falls assessment service and conversely the falls clinics refer to us. Where possible we try to arrange assessments on the same day. There is some evidence that this type of service reduces demand on secondary hospital care, reduces social care costs and there is clearly an opportunity to identify and manage continence problems. Education is key to ensuring the treatable nature of the problem is recognised. Secondary care continence services work best as part of the continuum of integrated continence services, and this is especially true for the frail older person who is likely to have long-term problems and comorbidities. The advent of clinical commissioning groups may influence where services are delivered but it is important that as geriatricians we "get alongside" our primary care colleagues and help influence commissioning decisions.

Model 2: The Geriatric continence service within the CoE department

Dr Tammy Angel, Consultant in Elderly Care West Hertfordshire Hospitals NHS Trust

When setting up a geriatric continence service there is an element of feeling like you are talking to a brick wall. Incontinence is not a part of the normal ageing process.

In a recent national audit of continence services in the UK, it was found that there was poor identification of continence problems, poor documentation of basic assessment, poor investigation and management, patients received no written information about their condition and had no "user input." There was also no integration between primary and secondary care services.[1]

Our goal with our service was to improve in-patient management of incontinence, organise appropriate and better follow up and start an out- patient service. We started with a Trust-wide survey: all acute medical wards were screened, which included 258 patients in 10 wards. Of these patients, 20% were currently catheterised, 50% had been previously catheterised , 20% were wet and 25% required a catheter.

Developments in the service included a care pathway for management of UI and a screening tool for referrals. We also presented a business case for bladder scanners. The use of these scanners would reduce the number of urinary catheterisations and expenditure on practitioner time and disposables. It would also reduce the number of catheter related urinary tract infections (UTI), which on average cost an acute Trust £1,327 per patient, and reduce the length of stay. West Hertfordshire's statistics show a mean length of stay of 14.3 days for patients with an indwelling catheter versus 9.3 days for non-catheterised patients. The business case also included the cost of minimising the risk of device related MRSA bacteraemias as within West Hertfordshire Trust (2004–2007), 35% of patients with bacteraemias were catheterised prior to positive blood culture. Overall 5200 bladder scans were performed last year, which meant that 3100 catheters and 550 UTIs were avoided saving a total of £746,400.

Six years on we now have an in-patient service with access to bladder scanners, an out-patient service, a medical "trial without catheter" service, and a continence nurse support worker. We have also raised the profile of bladder and bowel care for inpatients.

In conclusion, a continence service can add value and this reflects positively on the care of the elderly department.

1. http://www.rcplondon.ac.uk/resources/national-audit-continence-care. Accessed 31/10/11

Model 3: The Geriatrician working between the community and secondary care

Dr Natasha Arnold, Consultant Geriatrician in Intermediate Care, Homerton University Hospitals NHS Foundation Trust

The intermediate care geriatrician does not work alone. Among our colleagues are the adult community care rehabilitation team, GPs, dementia community support team, first response duty team and community matrons.

Our intermediate care service involves three community multi-disciplinary teams (MDTs) with time defined goals who carry out comprehensive geriatric assessments (CGA) to facilitate early discharge or prevent admission. We also have a rapid access phone advice service that runs from Monday to Friday (9am–5pm). GPs, community matrons and MDTs can ring for urgent assessment or coordinate admission prevention strategies.

We also have a rapid access MDT clinic daily to see urgent cases within 24 hours for a CGA and treatment plan. This clinic can incorporate up to three new patients a day to include an incontinence assessment.

The draft continence pathway for our Trust starts with the patient with newly identified UI. They will then have a complete primary assessment for urinary/faecal or combined incontinence. Then one of three things will happen. The first is that the patient's symptoms resolve or improve and they are confident with ongoing management. This patient will then continue in the community with a review of symptoms if they recur. The second is that the patient is referred to a specialist urinary service such as a continence (CNS—consultant nurse specialist) clinic, catheter clinic, urology clinic or Bryning geriatric clinic. The third is that the patient will be referred to a specialist service for review of faecal continence. Specialist services will review response to intervention to aid patient self management and assess quality of life scores. When urinary or faecal continence continues to impair quality of life the patient will be referred to either urogynaecology, catheter review in urology or to a GI tract specialist /CNS to consider surgery.