

Chapter 13

Continence

13.1 Key audiences

Primary care trusts:

- commissioners of services for older people
- directors of public health
- directors of community nursing
- GPs.

NHS trusts:

- medical directors
- clinical leads for elderly care medicine
- clinical leads for urology
- clinical leads for women's health
- clinical leads for gastrointestinal surgery
- care of the elderly physicians
- directors of nursing
- allied health professionals.

Nursing homes:

- managers.

13.2 Key issues and concerns

- Despite the existence of good practice guidelines on continence services from the Department of Health since 2000, and a milestone for integrated continence services in the *National Service Framework for Older People*, these services are often unavailable to those who need them.
- Where services do exist they are not integrated and often substandard.
- Urinary incontinence is particularly prevalent in women and older people.
- Faecal incontinence is prevalent in very elderly people and those in residential care.

- Incontinence is a common reason for entering a care home.
- Incontinence places a considerable stress on carers and is often the main reason for the breakdown of the caring relationship between an older person and their carer.
- It is not just the physical aspect of incontinence that is distressing but also the psychological and social effects.
- Continence is often a treatable condition.

Lack of availability of comprehensive continence services

Despite the existence of good practice guidelines on continence services from the Department of Health since 2000, continence services are often unavailable to those who need them³¹⁹ and are neglected, underfunded and not integrated.³²⁰

Incontinence is a particular issue for older people

Urinary incontinence is particularly prevalent in women and older people. Between 1 in 10 and 1 in 5 women over 65 have urinary incontinence and between 1 in 14 and 1 in 10 men aged over 65 have urinary incontinence.³²¹

1 in 3 people in residential homes, nearly 2 in every 3 in nursing homes and 50 per cent to 66 per cent of those in general wards for older people, and older people's mental health wards, have urinary incontinence.³²²

17 per cent of very elderly people have symptoms of faecal incontinence and in residential care about 25 per cent have faecal incontinence.³²³

Incontinence is second only to dementia as the main reason for entering a care home. For carers, incontinence can be the 'last straw' and is often the main reason for the breakdown of the caring relationship, leading to admission to residential care.³²⁴

It is not just the physical aspect of incontinence that is distressing but also the psychological and social effects. The impact on older people's quality of life and loss of dignity is shocking – and unnecessary. Incontinence has been linked in various studies to depression and even suicide.^{325 326}

³¹⁹ *National Service Framework for Older People*, Department of Health, 2001

³²⁰ *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

³²¹ *Good Practice in Incontinence Services*, Department of Health, 2000

³²² *Good Practice in Incontinence Services*, Department of Health, 2000

³²³ *Good Practice in Incontinence Services*, Department of Health, 2000

³²⁴ *Good Practice in Incontinence Services*, Department of Health, 2000

³²⁵ *Indications of public health in the English regions. 9: Older people*, Association of Public Health Observatories and West Midlands Public Health Observatory (APHO), 2008

www.wmpho.org.uk/resources/APHO_OP.pdf

³²⁶ *Incontinence – Help the Aged Policy Statement*, Help the Aged, 2008

Continence is often a treatable condition and continence services are particularly important to older people.^{327 328}

Guidance on continence services is often not implemented

An audit by the Royal College of Physicians in 2006 (the most recent though another is due to report in 2010) showed that whilst there is some basic infrastructure for these services, there remains inadequate access to integrated services and when someone is identified as having a problem they do not necessarily get an assessment. Only 66 per cent of primary care sites, 56 per cent of hospital sites, 63 per cent of mental health care sites and 69 per cent of care homes offered an integrated continence service.³²⁹

In hospitals, only half of the patients with urinary incontinence have a history taken and a specialist assessment done. In only 34 per cent of cases is a diagnosis documented. Fifty-eight per cent of patients are not actively treated, but are either given pads or are catheterised. This is not in line with Department of Health recommended good practice.³³⁰

NHS trusts have varied policies on providing continence services to care homes and differences in provision could mean that clients do not receive a standardised assessment and that their treatment and management is subsequently poor.³³¹

A large number of care homes and community services put a restriction on the numbers of continence pads per person per day.³³²

It is still not unusual for patients in hospital wards to have to use commodes, rather than staff taking them to the toilet when needed.³³³

Older people still complain about delays in call bells being answered, resulting in the person being unable to use the toilet when it is needed. Older people report subtle or not so-subtle pressure to use incontinence pads, or even to soil their bedding, rather than make repeated or urgent requests to use the toilet.³³⁴

³²⁷ *Good Practice in Continence Services*, Department of Health, 2000

³²⁸ *National Service Framework for Older People*, Department of Health, 2001

³²⁹ *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

³³⁰ *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

³³¹ *Continence care and policy initiatives*, De Laine C, Scammell J and Heaslip V, Nursing Standard vol 17, no 7, 2002

³³² *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

³³³ *Behind Closed Doors: using the toilet in private*, British Geriatrics Society, 2006

³³⁴ *The Challenge of dignity in care – Upholding the rights of the individual*, Levenson R, Help the Aged, 2007

13.3 Drivers and policy imperatives

The Department of Health indicates that all necessary policy with respect to continence is in place; what is lacking is implementation of that policy.³³⁵ *Good Practice in Continence Services*³³⁶ sets out the evidence base, procedures, guidelines and targets for an integrated continence service across primary, community and acute care.

The *National Service Framework for Older People*³³⁷ re-emphasised the importance of integrated continence services to support older people and their carers and stressed that they should be established as a priority (NSF Standard 2). The NSF included a milestone that all local health and social care systems should have established an integrated continence service by April 2004. (More recent RCP audits would suggest that these are still not in place in many localities.)

The *Essence of Care*³³⁸ benchmarks support good practice in continence services.

The NICE guidance on continence services refers largely to *Good Practice in Continence Services*³³⁹ and in addition provides:

- Guidance on commissioning a urinary continence service:
→ www.nice.org.uk/usingguidance/commissioningguides/uiwomen/CommissioningAUCService.jsp
- Guidance on commissioning a faecal continence service:
→ www.nice.org.uk/usingguidance/commissioningguides/faecalcontinenceservice/CommissioningFaecalContinenceService.jsp
- Clinical Guideline 40 – *The management of urinary incontinence in women*, 2006
- Clinical Guideline 49 – *Faecal incontinence: the management of faecal incontinence in adults*, 2007.

The Dignity in Care Campaign stresses the need for people receiving services to be involved in decisions about their personal care and to “enable people to maintain the maximum possible level of independence, choice and control” (Dignity Challenge Point 4).

It is anticipated that the *Prevention Package for Older People* will include guidance on continence services:

³³⁵ *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

³³⁶ *Good Practice in Continence Services*, Department of Health, 2000

³³⁷ *National Service Framework for Older People*, Department of Health, 2001

³³⁸ *Essence of Care*, NHS Modernisation Agency, 2003

³³⁹ *Good Practice in Continence Services*, Department of Health 2000

13.4 What good age-equal practice might look like

Making continence services a priority and ensuring that an integrated continence service is in place would be an effective means by which local health organisations could demonstrate their commitment to promoting age equality.

*Good Practice in Continence Services*³⁴⁰ sets out what commissioners and providers need to do in order to provide integrated continence services. It also sets targets and provides guidance for residential care and nursing homes and for inpatient care.

It is also important for primary care trusts to work with local authorities on wider issues to promote continence, such as the provision of public toilets.

The 2006 Royal College of Physicians audit of continence services³⁴¹ stressed the following issues that needed addressing:

- People with continence problems should be treated once a problem is identified. To neglect or ignore a problem once detected is clearly inadequate care. This is a point of action for all healthcare staff, in all settings.
- Integrated continence services for all adults, contained in “Good Practice in Continence Services” and reiterated in the National Service Framework, should be the goal, but remains a distant one in most areas. A considerable amount of organisational change is still required to meet the target. Commissioners of services need to bear this in mind when specifying their needs.
- All staff should be trained in basic assessment and management of this troublesome condition. Training should be accessible to all and should be made a mandatory component of basic training for staff.
- Handover between staff caring for older people with continence problems relies upon adequate documentation to maximise efficient use of resources. However, documentation of continence assessment and management for older people is wholly inadequate. This is clearly an example of substandard practice and should be relatively easy to improve upon.

³⁴⁰ *Good Practice in Continence Services*, Department of Health, 2000

³⁴¹ *National audit of continence care for older people (65 years and above) in England, Wales and N Ireland*, Wagg A, Peel P, Lowe D and Potter J, Royal College of Physicians, 2006

- In each service there should be a designated lead with responsibility for organisational change towards an integrated continence service. Commissioners need to ensure that provision, probably across provider units, with the relevant skilled staff is available to their population.
- People should have a proper assessment in order to get an accurate diagnosis. A lack of proper assessment will lead to either unnecessary treatment or inappropriate reliance upon containment of the problem. The needless use of pads is expensive and potentially undignified.
- Catheters should only be used for the management of incontinence after a thorough assessment of the problem and where other methods have either failed or the patient is too frail or too distressed to tolerate other more labour-intensive measures.

The British Geriatrics Society *Behind Closed Doors* Dignity Campaign provides action plans and tools to ensure that people, whatever their age and physical ability, are able to choose to use the toilet in private in all care settings:

→ www.bgs.org.uk/index.php?option=com_content&view=category&id=60&Itemid=169

13.5 Case studies of illustrative / good practice

Model documents

The Royal College of Physicians provides generic continence policy material, assessments and care pathways:

→ <https://audit.rcplondon.ac.uk/continence2006/modules/page/Page.aspx?pc=1301&mid=56&pmid=0>

Using technology to promote continence in a home setting

The following example, from Hanover SmartChoice, a service that helps care providers assist older people and people with disabilities to maintain their independence and remain safely in their own homes, demonstrates how assistive technology can help restore dignity.

Mrs J is a resident of an Extra Care scheme. When carers noticed an increase in her incontinence, the standard approach was for carers to enter her room at night and feel her bed to see if she had soiled herself. This was unsatisfactory for all. The solution was to use an enuresis pad which issues an alert if Mrs J is incontinent. This allows for carers only to enter her room when an incident occurs, and if she is incontinent she is assisted with her toilet needs and bedclothes are changed straight away. It also enabled carers to examine records of alerts. They could see that a pattern of incontinence developed between 2 and 3am. Using this information carers can now assist Mrs J to the toilet at 1.30am and promote her continence.

Source: SCIE *Dignity in Care Practice Guide*

→ www.scie.org.uk/publications/guides/guide15/challenge/index.asp

13.6 Suggestions for quick wins / what you can do now

- Look at results of the 2009 - 2010 Royal College of Physicians audit with all stakeholders and make an action plan to improve.
- Ensure that there is a suitably trained clinical nurse specialist for continence management in all acute and community trusts.
- Ensure that local hospitals have multi-disciplinary consultant-led teams to coordinate continence services.
- Audit local hospitals and nursing homes to ensure that older people are not using commodes or incontinence pads inappropriately and that assistance is given to take people to the toilet when required.
- Review policies on rationing of continence pads in community, hospital and residential care settings.
- Audit and review use of catheters for incontinence in hospital settings.
- Ensure there is a designated lead in the primary care trust for continence services.