

## Identifying incontinence on an aged care ward: Results of screening phase of an implementation study

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**Introduction:** Individuals over 80 years are four times more likely to be incontinent than younger people.<sup>1</sup> Urinary incontinence (UI) during hospital admission is associated with a longer hospital stay,<sup>2</sup> less independence in self-care<sup>3</sup> and requiring supervision to walk. Despite this threat to independence, UI is rarely addressed during inpatient care.

**Objectives:** The aim was to develop a new way to recognise UI in older hospitalised patients. The specific objective was to report findings from the screening phase of the implementation study to identify UI or faecal incontinence (FI) during sub-acute aged care hospital admission.

**Methods:** An incontinence screening process was implemented for admissions to a tertiary metropolitan hospital sub-acute aged care physiotherapy ward service between June and December 2022. Clinical measures and multidisciplinary electronic medical record (EMR) data were also scrutinised to identify presence of incontinence symptoms. Measures of implementation of the screening tool included proportion of patients that screened positive for UI/FI, agreement between different screening methods, and staff acceptability.

**Results:** A pre-study spot audit (n=10) of patient files identified: 80% without fluid intake documentation, 80% no measured voids, 70% without post-void residual ultrasound measures, 40% documentation of containment products being changed and continence intervention documented 20% of the time. Bowel action were recorded without stool type in 90% of patients; FI was documented in all cases.

Physiotherapists screened for incontinence 83% of the time. Of the 106 patients screened, 89 were capable of self-reporting symptoms. The mean age was 84.5 years (SD 7.6). Overall, 50% screened positive for incontinence. Screening was limited by patient confusion, dementia, delirium, aphasia, drowsiness, and/or refusal. Only 75% of physiotherapists found continence screening a good match to their knowledge and skillset, although all believed continence screening to be relevant and important. Physiotherapists did not find the screening questions easy to include in their assessment. The major barriers impacting questionnaire completion were patient factors including impaired cognition, poor health literacy, or difficulty with recall.

Specific symptom prevalence from the screening questions: UI 27%; urinary urgency 39%; urinary frequency 69%; and FI 16%. Multidisciplinary documentation indicating incontinence was identified in medical notes 21%, occupational therapy notes 37%, fluid balance chart 40% and 19% for UI and FI respectively.

EMR documentation agreement with patient response to screening questions occurred in 55% of cases; different sources of incontinence data showed disagreement in 40% of cases. Although poorly completed, the Functional Autonomy Measurement System items most closely aligned with patient report of incontinence (prevalence of 46%).

With respect to the characteristics of older patients with incontinence, there was no difference in age, sex, clinical frailty, or use of a gait aid when compared to continent inpatients. Incontinent inpatients evidenced more delirium, a higher number of medications, lower mobility and more urinary tract infections than continent inpatients.

**Conclusion:** EMR documentation of incontinence should be optimised. Digital alerts can then be used to trigger investigative data collection that informs individualised treatment of underlying causes of incontinence in older patients during a hospital stay.

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