A guide to assessing bladder function and urinary incontinence in older people

An overview of the causes of incontinence in older people, its diagnosis and management, and how bladder function and structure changes with age.
urge incontinence, and alpha-blockers prescribed for hypertension can weaken the urethral muscle, resulting in stress incontinence.

Many medicines can have an adverse effect on bladder and bowel function, so when an older person with incontinence or bladder symptoms is being assessed, a medication review should be undertaken.

Diabetes mellitus occurs in 15-20% of frail older people (Fonda et al, 2005) and can result in a range of bladder problems, including polyuria, urinary retention and urinary tract infection.

Older people with chronic chest conditions, such as COPD, are at an increased risk of stress incontinence due to the strain on the pelvic floor muscle as a result of coughing.

Congestive heart failure can contribute to nocturnal polyuria, nocturia and nocturnal enuresis. Diuretic medication for heart failure can cause daytime urgency, frequency and incontinence.

Severe constipation is a common problem in older people and faecal impaction can cause urinary retention and both urinary and faecal incontinence.

Neurological conditions such as stroke and Parkinson’s disease may interfere with the nervous pathways that control bladder function, resulting in urgency, frequency and, sometimes, retention of urine.

Older people with dementia may have good bladder function but, because of cognitive impairment and mobility problems, are often unable to recognise the need to pass urine or to find the toilet. This can result in “inappropriate voiding”, when, for example, the older person with dementia voids in a waste bin or similar receptacle.

**ASSESSMENT OF THE OLDER PERSON WITH BLADDER DYSFUNCTION**

When assessing the older person with incontinence or bladder dysfunction, a holistic and comprehensive approach is essential. It is important not to have any preconceived thoughts as to causes.

The person may be embarrassed and ashamed, and therefore time should be set aside to talk about their feelings. The underlying cause is often multifactorial and the nurse has to undertake the role of detective to try to identify it.

It is advisable to use an assessment tool to guide the assessment process and ensure that all the essential information is gathered. This is vital if a balanced judgement about the cause of the problem is to be made.

The bladder record diary has been cited as the single most valuable tool in assessing urinary incontinence (Norton, 2001). NICE (2006) recommends maintaining a three day bladder diary (Box 1, p22).

Symptoms of urgency, frequency and nocturia and urge incontinence are all indicative of an overactive bladder, while leaking on coughing, sneezing and exertion are more likely to suggest stress urinary incontinence.

The amount and type of fluid drunk can affect continence. Drinks containing caffeine, such as coffee and tea, or alcohol may cause increased urgency and frequency and it may be helpful to reduce this type of fluid (Wilson et al, 2005). However, total fluid intake should be 2L a day.

Urinalysis is an essential part of a continence assessment, providing valuable information that can lead to a diagnosis or disprove a suspected condition. It is advisable to dip test urine with a multiproperty reagent stick to detect any abnormalities.

A detailed medical and surgical history should be taken, as well as a list of all medications, including over the counter medications. The potential side effects of these should be checked to find out if the bladder symptoms may be related to them.

A bladder scan should be taken to assess post-micturition residual bladder volume of urine. There is no evidence-based agreed specific maximum post residual volume that is considered normal or a minimum post residual volume that is considered abnormal.

When assessing the significance of a bladder residual volume, it is important to look at the bladder function and symptoms before considering any intervention such as intermittent catheterisation.

With an older person’s informed consent, it may be appropriate to undertake a vaginal or digital rectal examination. This should only be done by a practitioner who has been trained and is competent in the procedure. Such an examination can determine the strength or weakness of the pelvic floor muscles, and also identify conditions such as prolapse, vaginal atrophy, constipation and BPH. The modified Oxford grading system may be used to grade the strength and endurance of the pelvic floor muscles (Laycock and Haslam, 2002).

An abdominal examination should be undertaken by a doctor or nurse practitioner to exclude an abdominal mass and, in men, a digital rectal examination is carried out to assess the prostate gland. The doctor may also take blood to measure the prostate specific antigen (PSA) which, if raised, may indicate prostate cancer.

In people known to have problems with cognitive function, for example if they have dementia, their ability to recognise the need to void and that the toilet is the appropriate place to void should be assessed.

It is also important to assess people’s ability to reach the toilet unassisted and, if not, whether they have appropriate help.

For people with mobility problems, for example as a result of a stroke, a functional assessment should be undertaken to ensure
that they can access the toilet, commode or urinal independently and, if not, that help is readily available.

**PLAN OF CARE FOLLOWING ASSESSMENT**
A good assessment will help to identify any underlying causes of the incontinence and enable treatment to be initiated. The options should be discussed with the older person, their willingness and ability to participate in self-help strategies assessed and a clear explanation should be given to the individual and/or carer.

Patients’ preferences for care must be established and the care plan individualised with patient-centred goals (Fonda et al, 2005). In frail older people, some interventions may be inappropriate, but advanced age alone should not preclude treatment if the assessment identifies that it is necessary (Fonda et al, 2005).

Conservative therapies such as bladder retraining, ensuring a good fluid intake, reducing caffeine, constipation management and pelvic floor exercises are effective.

Referral to a urotherapist may be advisable for further pelvic floor assessment and re-education if the pelvic floor muscles are weak.

There is evidence that prompted voiding during the daytime for older people in care homes is effective (Fonda et al, 2005). Older men with benign prostate disease may be managed with medication, for example alpha-blockers. Those with early prostate cancer may be carefully monitored with regular blood tests for PSA, digital rectal examination and observation of symptoms. Other treatment options include surgery and radiotherapy. Advanced prostate cancer may be treated with hormonal therapies and the symptoms monitored.

Antimuscarinic drugs for overactive bladder should be prescribed with caution in older people because of the risk of interactions with other medications, the effect of coexistent disease and the risk of side effects such as impaired cognitive function (Wagg, 2007).

There is trial evidence in the following for frail older people:
- Darifenacin;
- Oxybutynin, modified release;
- Solifenacin;
- Tolterodine (Wagg, 2007).

NICE (2006) recommends the use of topical oestrogen for vaginal atrophy and reported that it could also improve symptoms of frequency, dysuria and urge or stress urinary incontinence.

**REFERENCES**


