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HEARTS, minds and souls – it's time for geriatricians to bring more to continence management

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Keywords:	Incontinence, Communication, Frailty, Older people, Guidelines
Keypoints:	Urinary incontinence (UI), the involuntary loss of urine, is a common health condition that may decreases quality of life, Due to stigma, many older adults do not volunteer incontinence symptoms to their primary care provider, Communication skills in continence care are a vital part in the treatment of older patients

HEARTS, minds and souls – it's time for geriatricians to bring more to continence management

Urinary incontinence (UI), the involuntary loss of urine, is a common health condition that may decrease quality of life and which increases in incidence and prevalence with age. Recent epidemiologic data suggest an overall prevalence of 38% in women older than 60 years, increasing to 77% in older women living in nursing homes[1]. Despite this high prevalence, incontinence remains underdiagnosed and undertreated in this age group. In a representative population of 7000 participants drawn from the Irish Longitudinal Study of Ageing, 750 had urinary incontinence, of which 285 (38%) had not sought the help of a healthcare professional[2].

The reasons that older people don't seek help for incontinence are complex and multiplex. Stigma surrounding diagnosis, a sense of futility coupled to a notion that incontinence is a part of normal ageing, and the fact that incontinence simply gets "lost" in the midst of multimorbidity and frailty have all been shown to play a role[3]. Active case finding has therefore been highlighted as a cornerstone of effective care in serial international guidelines.

HEARTS

Core principles of good communication in care of older people - that communication be responsive, empathetic, individualised, person-centred, and devoid of ageism – are particularly helpful when tackling sensitive issues such as incontinence. We have drawn these principles together here using a mnemonic – HEARTS.

Humanity

Avoid ageist assumptions when providing information, including pre-conceived notions about how age may affect impact of incontinence or treatment decisions.

Attend to the balance of technical and emotional content when discussing treatment regimens with older patients. Show compassion and be gentle.

Respond to continence care needs in a timely manner, whether establishing treatment plans in clinic, or providing personal care day-to-day. What is routine for staff is frequently an urgent priority for the patient.

Empathy

Acknowledge the stigma associated with incontinence and how this impacts on the patient.

Recognize that fear and uncertainty related to the aging process and emerging frailty may be tied up with the continence diagnosis.

Autonomy

Seek to understand older adults' cultural beliefs and values and how these relate to illness.

Work harder to protect and respect autonomy in decisions for those with cognitive impairment who may find it more difficult to participate in discussions and who are at risk of finding their preferences overlooked.

Adopt a relationship-centered approach that includes listening to and involving family members, carers and the patient. Understand that older people with frailty and/or cognitive impairment frequently rely upon those around them to maintain autonomy and independence.

Respect

Remember that small gestures go a long way to maintain personal dignity, e.g. being discreet in questioning, closing doors and curtains, recognizing that patients may not want family or professional carers to be party to all discussions.

Cultivate an unrushed consultation style that helps patients feel able to raise issues around unmet need.

Trust

Recognize that trust is central to effective discussion of personal issues. It may require multiple consultations to build this over time.

Knowing and understand a person's biography, and showing that you recognize and are working to accommodate their values and beliefs is integral.

This personalized approach to care extends to understanding that values and beliefs impact on how treatments, both behavioral and pharmacological, are incorporated into daily routine, and hence their effectiveness.

Shared planning

- Make sure that treatment does not stop with assessment, ensure that a management plan is established, with goals, and organize to meet again to review progress against these.

- Engage in shared decision-making, recognizing that different patients will want different levels of guidance and support from professionals.
- Ensure that you explore the full range of potential therapies with patients and their families – including non-pharmacological, and surgical interventions. Advocate for access to more intensive treatments where this aligns with patient priorities.

When we first drafted this paper, we had planned to stop there. A simple thesis that communication approaches well-established in specialist care for older people could support effective continence care. But as we worked on this, and received feedback from peer-reviewers, we were encouraged to do more. The assertion was, that HEARTS was not enough, geriatricians had to bring their minds and souls to continence care as well.

Minds

The frail older persons committee of the International Consultation on Incontinence (ICI) articulated the barriers to accessing continence care for older adults as including[3,4]: a paucity of research evidence and guidance that recognises the specific challenges of providing care in older people; systematic and organisational approaches to care delivery that exclude older people; and a lack of training that enables staff to grapple with the complexity of continence care in older adults. They highlighted the technical complexity of continence care in this group – including how aging physiology challenges diagnosis, and the interaction of personal and environmental factors, including polypharmacy and multimorbidity.

Complexity and multimorbidity is the raison d'etre for geriatricians and the multidisciplinary teams they work with. Comprehensive Geriatric Assessment (CGA) is well established as an evidence-based approach to care of older people with frailty, regardless of setting[5]. The structures required to deliver CGA in acute hospital care[6], rehabilitation[7] and peri-operative care of older people[8] are now well described. Even where the terminology of CGA may engender resistance – for example in primary care delivery to care homes – it has been shown to embody the core principles of patient-centred management in the context of frailty[9]. Yet, whilst national and international guidelines on incontinence recommend, for example, accounting for "the individual needs, preferences and values of their patients or the people using their service,"[10] they fail to signpost, reference or take account of the substantial literature, from CGA, about how to operationalize multidisciplinary, multimodal assessment of older people with frailty.

The most detailed review of how context influences implementation of continence care was a realist review focusing on faecal incontinence in care homes[11]. This study identified key themes to be: (1) clinician-led support, assessment and review, (2) teaching and support for care home staff, (3) the causes and prevention of constipation, (4) how the cognitive and physical capacity of the resident affect outcomes, (5) how the potential for recovery, reduction and management of FI is understood by those involved and (6) how the care of people living with dementia and FI is integral to the work patterns of the care home and its staff. There was a paucity of literature that accounted for the impact of dementia on continence care. Much of the remaining literature on care processes and continence has gotten as far as outlining problems – but is less forthcoming when it comes to solutions[3]. Geriatricians and their teams have expertise in implementing structured approaches to managing complex long-term conditions in older people, and indeed have had considerable success when applying these principles to continence care[12]. Their expertise is needed to develop and implement such care models at scale and pace.

Souls

Although present in undergraduate[13] and postgraduate[14] curricula in geriatric medicine, and despite being one of the original "Geriatric Giants"[15], continence has not established a foothold in the mainstream of geriatric medicine in the way that other subspecialties have. Subspecialty posts focusing on continence are rarely funded or advertised. Outside of the work of the ICI, the expertise of geriatricians is frequently not given prominence in guidelines, which focus predominantly on the urogynaecological aspects of care. Our call to arms in this commentary is part of a longstanding trend for enthusiasts to proselytize evangelically about the importance of geriatricianly expertise in continence care, whilst the necessary skills to deliver such services effectively for our patients go undeveloped by most practitioners, and the necessary services to effectively deliver continence care to older people with frailty go undeveloped in most places.

We have outlined in this article that the skills in communication (HEARTS), and complex care delivery and service development (minds) required to improve continence care are already well defined and held within the body of specialists responsible for care of older people. Geriatricians and their teams don't, though, for the most part have the technical skills in continence assessment and management to manage the more urogynaecological aspects of care. The template for success lies, perhaps, in the way that orthogeriatrics has been developed nationally and internationally through partnership between geriatricians and orthopaedic surgeons, or the way that perioperative care for older people has been progressed under the auspices of the multi-speciality Age Anaesthesia Association. National and international leadership in our specialty will be required to take

this forward. It's not just HEARTS and minds that we need, but to put our souls into this as well.

References

1 Lukacz ES, Santiago-Lastra Y, Albo ME, *et al.* Urinary incontinence in women a review. JAMA - Journal of the American Medical Association. 2017;**318**:1592–604. doi:10.1001/jama.2017.12137

2 Sullivan R, McNicholas T, Claffey P, *et al.* Unreported urinary incontinence: population-based prevalence and factors associated with non-reporting of symptoms in community-dwelling people ≥ 50 years. *European Geriatric Medicine* 2020;**12**:405–12. doi:10.1007/s41999-020-00412-0

3 Gibson W, Johnson T, Kirschner-Hermanns R, *et al.* Incontinence in frail elderly persons: Report of the 6th International Consultation on Incontinence. Neurourology and Urodynamics. 2021;**40**:38–54. doi:10.1002/nau.24549

4 Wagg A, Gibson W, Ostaszkiewicz J, *et al.* Urinary incontinence in frail elderly persons: Report from the 5th International Consultation on Incontinence. *Neurourology and Urodynamics* 2015;**34**:398–406. doi:10.1002/nau.22602

5 Welsh TJ, Gordon AL, Gladman JR. Comprehensive geriatric assessment - a guide for the non-specialist. *International journal of clinical practice* Published Online First: 7 October 2013. doi:10.1111/ijcp.12313

6 British Geriatrics Society. Quality Care for Older People with Urgent and Emergency Care Needs (the Silver Book) available online at http://www.bgs.org.uk/campaigns/silverb/silver_book_complete.pdf (last accessed Nov 25th, 2015).

7 Grund S, Gordon AL, van Balen R, *et al.* European consensus on core principles and future priorities for geriatric rehabilitation: consensus statement. *European Geriatric Medicine* Published Online First: 2019. doi:10.1007/s41999-019-00274-1

8 Gordon AL, Evans BJ, Dhesi J. The physician's role in perioperative management of older patients undergoing surgery. *Clinical Medicine, Journal of the Royal College of Physicians of London* 2017;**17**. doi:10.7861/clinmedicine.17-4-357

9 Devi R, Chadborn NH, Meyer J, *et al.* How quality improvement collaboratives work to improve healthcare in care homes: a realist evaluation. *Age and Ageing* 2021;:1–11. doi:10.1093/ageing/afab007

10 NICE Guidance - Urinary incontinence and pelvic organ prolapse in women: management: © NICE (2019) Urinary incontinence and pelvic organ prolapse in women: management. *BJU international* 2019;**123**:777–803. doi:10.1111/bju.14763

11 Goodman C, Norton C, Buswell M, *et al.* Managing faecal incontinence in people with advanced dementia resident in care homes (FINCH) study: A realist synthesis of the evidence. *Health Technology Assessment* 2017;**21**:1–219. doi:10.3310/hta21420

12 Yoo R, Spencer M. Continence promotion and successful aging: The role of the multidisciplinary continence clinic. *Geriatrics (Switzerland)* 2018;**3**. doi:10.3390/geriatrics3040091

13 Masud T, Blundell A, Gordon AL, *et al.* European undergraduate curriculum in geriatric medicine developed using an international modified Delphi technique. *Age and ageing* 2014;:afu019-. doi:10.1093/ageing/afu019

14 Roller-Wirnsberger R, Masud T, Vassallo M, *et al.* European postgraduate curriculum in geriatric medicine developed using an international modified Delphi technique. *Age and Ageing* 2019;**48**. doi:10.1093/ageing/afy173

15 Morley JE. A brief history of geriatrics. *The journals of gerontology Series A, Biological sciences and medical sciences* 2004;**59**:1132–52. doi:10.1093/gerona/59.11.1132

Response to Reviewers

Title: HEARTS, minds and souls – it's time for geriatricians to bring more to continence management

Reviewers Comments	Response	Response Text
Associate editor		
Continence is a topic that I am keen to highlight and promote in Age and Ageing. This is an interesting commentary, mainly about communication, attitudes and approach	Thank you	
However, there is little reference to technical aspects of assessment and management, or how we should deliver best care. We cannot rely on just humanity and empathy if we are to make a real difference. Without going into details (Reviewer 1 points to algorithms), this aspect needs to be at least signposted. There is much more to continence care than prescription of anti-muscarinics and pads.	Thanks – we have substantially recrafted the article, to highlight technical aspects, not just of management of complex conditions, and the urogynaecological expertise required for effective continence care but also in terms of the implementation science that has yet to be widely deployed in the context of incontinence.	
BTW 'C' in COM-B stands for Capability		
Referee: 1		
The introduction and background exclude the ICS guidelines on incontinence in older people. The reference given (reference 6) is the entirety of the 6th ICI. The quotation given is missing the start of the sentence, which thin introduces a grammatical error which has been flagged with [sic] – had the sentence been quoted in full this would not have been needed.	Thankyou – the "sic" was to highlight out discomfort with the word "sufferer", which is not a term we are comfortable with or would commonly use. Preferring, instead to talk of people "living with" a long-term condition. This is keeping with patient and public involvement recommendations. But we've not taken this quote out for space purposes.	**The quote is no longer in the article.**

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The specific guidelines regarding incontinence in frail older people were published from both the 5th ICI (https://onlinelibrary.wiley.com/doi/abs/10.1002/nau.22602) and the 6th ICI (https://pubmed.ncbi.nlm.nih.gov/33085806/). Both these versions include an algorithm for the management of incontinence in older people, in which the first step is active case finding. In addition, several articles address the issue of active case finding in a variety of settings, for example community pharmacies (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6610509/), and these are not referenced nor covered. As such the authors have not really established any kind of problem before trying to solve it. There are multitude of reasons that older adults do not seek help for LUTS and receive less evidence-informed care when they do, which requires a much more detailed discussion.	Thankyou we – have now incorporated these guidelines into the text and have used them to articulate the full range of barriers that may impede older people's access to continence services. We have used this to lead us to the topic of communication – and hence the HEART mnemonic.	**Throughout the text. We have drawn heavily on these resources now. We draw explicit reference to them here: "**The frail older persons committee of the International Consultation on Incontinence (ICI) articulated the barriers to accessing continence care for older adults as including[3,4]: a paucity of research evidence and guidance that recognises the specific challenges of providing care in older people; systematic and organisational approaches to care delivery that exclude older people; and a lack of training that enables staff to grapple with the complexity of continence care in older adults. They highlighted the technical complexity of continence care in this group – including how aging physiology challenges diagnosis, and the interaction of personal and environmental factors, including polypharmacy and multimorbidity."

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I am unsure how the mnemonic proposed relates specifically to incontinence. It seems to be a broadly applicable to communication with anybody and has no specific applicability to continence any more than it would to depression, cognitive impairment, or any other "delicate" subject. It may be worth expanding the paper to cover communication in general.	Thank you – we have been clear that this is about bringing good principles of communication already built into geriatric medicine practice, together in one place. We have said this, explicitly, in multiple parts of the article.	**"**Core principles of good communication in care of older people - that communication be responsive, empathetic, individualised, person-centred, and devoid of ageism – are particularly helpful when tackling sensitive issues such as incontinence. We have drawn these principles together here using a mnemonic – HEARTS." "When we first drafted this paper, we had planned to stop there. A simple thesis that communication approaches well-established in specialist care for older people could support effective continence care. But as we worked on this, and received feedback from peer-reviewers, we were encouraged to do more. The assertion was, that HEARTS was not enough, geriatricians had to bring their minds and souls to continence care as well."
In addition, I feel that the mnemonic merely encapsulates some well-established and widespread communication practices, and this doesn't add much to the literature beyond encapsulating it into an acronym.	Thank you – we have made it clear that this is the case.	**As above.**
Referee: 2		

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Does the title completely reflect the content? Your article is also potentially a call to arms, for more Geriatricians to become involved in UI management and influence Guidelines and teaching. Could the title be tweaked to reflect this?	Yes – we have changed the title.	**The title is now: "HEARTS, minds and souls – it's time for geriatricians to bring more to continence management"**
You are correct to point out that current guidelines often mention the frailer older individual but the detail and the challenges inherent in actually addressing continence management in this group are not developed within the guideline in the same way as say a more technical surgical intervention. This point could be strengthened further in the article, perhaps drawing a comparison with the more easily defined interventions in fitter patient groups and the space devoted to them.	Thank you. We have adapted the text to address this point.	
Linked to point 2 - Supporting older people with UI takes time and resources and if guidelines are to be useful in underpinning service development and clinical practice, the complexities and approaches required need to be more explicitly set out in guidelines. Could be strengthened in the article.	We have substantially retooled the article to this end.	
The mnemonic is useful and although not specific to UI, is particularly relevant to UI given the sensitivities surrounding the subject area. The mnemonic concentrates on avoiding ageist assumptions and emphasizes the importance of clinician engagement with the individual, empathy and understanding the patient perspective. This is good.	Thank you. We have emphasised in the text that this is not unique to incontinence but that the principles are particularly useful in the context conditions.	**"**Core principles of good communication in care of older people - that communication be responsive, empathetic, individualised, person-centred, and devoid of ageism – are particularly helpful when tackling sensitive issues such as incontinence. We have drawn these principles together here using a mnemonic – HEARTS." "When we first drafted this paper, we had planned to stop there. A simple thesis that

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Perhaps two specific additional aspects could be incorporated into the mnemonic somehow a) Clinicians to specifically ask about continence issues, given that symptoms may not be volunteered (for some of the reasons given in your paper). You are correct in stating it`s about "responding to continence needs in a timely manner" but it`s also about sensitively opening the conversation with those without self-declared symptoms. ??This could be included in Humanity Section b) Clinicians to pursue relevant interventions if UI identified and following patient discussion. Perhaps this sounds obvious but UI is commonly noted in various assessments but often not addressed further. S could be added (HEARTS) to include specialist / specific actions / successful management ??? Alternatively it could be included in the Humanity section ie there is an obligation to do something if UI identified.	Thank you. We have added an "S" for "Shared Planning".	**S**hared planning - Make sure that treatment does not stop with assessment, ensure that a management plan is established, with goals, and organize to meet again to review progress against these. - Engage in shared decision-making, recognizing that different patients will want different levels of guidance and support from professionals. - Ensure that you explore the full range of potential therapies with patients and their families – including non-pharmacological, and surgical interventions. Advocate for access to

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		more intensive treatments where this aligns with patient priorities.
Might it be worth weaving into the article something more around the value of clinicians (Geriatricians/some Primary Care Physicians) who can also make assessments of co-morbidities and together with the patient can make balanced decisions about treatment interventions which cut across various conditions eg Cardiac failure management (diagnosis and medications) if UI present, use of anti-muscarinic agents if cognitive impairment present, value of CGA and involvement of allied healthcare professionals - (physiotherapy and occupational therapy) if functional issues. It might be worth providing one or two examples - again just suggestions.	Thanks – although we haven't used the example conditions described, we've substantially fleshed out, under "minds" why geriatricianly expertise in complex conditions is important.	**"**Complexity and multimorbidity is the raison d'etre for geriatricians and the multidisciplinary teams they work with. Comprehensive Geriatric Assessment (CGA) is well established as an evidence-based approach to care of older people with frailty, regardless of setting[5]. The structures required to deliver CGA in acute hospital care[6], rehabilitation[7] and peri-operative care of older people[8] are now well described. Even where the terminology of CGA may engender resistance – for example in primary care delivery to care homes – it has been shown to embody the core principles of patient-centred management in the context of frailty[9]. Yet, whilst national and international guidelines on incontinence recommend, for example, accounting for "the individual needs, preferences and values of their patients or the people using their service,"[10] they fail to

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		signpost, reference or take account of the substantial literature, from CGA, about how to operationalize multidisciplinary, multimodal assessment of older people with frailty."
Similarly, the complexities involved in delivering interventions for older people - eg changes in medication, application of topical treatments, liaison with other specialties and community services (padding and appliances) - requires a supportive infrastructure. Often seen as "simple" or "conservative", these interventions are actually complex to deliver consistently and at volume. Guidelines really need to bottom out the possible interventions for the older person in some detail (not just a mention about "conservative measures") and from which providers could then construct really relevant pathways . You make this point but it could be more explicit and emphasized more.	We have also added substantial amounts of text about service design and implementation which we believe addresses these points. We have first outlined the extent of the complexity of continence management based on a detailed realist review which was based around faecal incontinence, and then highlighted why geriatricianly expertise is important in this context.	**"**The most detailed review of how context influences implementation of continence care was a realist review focusing on faecal incontinence in care homes[11]. This study identified key themes to be: (1) clinician-led support, assessment and review, (2) teaching and support for care home staff, (3) the causes and prevention of constipation, (4) how the cognitive and physical capacity of the resident affect outcomes, (5) how the potential for recovery, reduction and management of FI is understood by those involved and (6) how the care of people living with dementia and FI is integral to the work patterns of the care home and its staff. There was a paucity of literature that accounted for the impact of dementia on continence care. Much of the remaining literature on care processes and continence

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Finally, you could be more challenging of organizations producing guidelines (as well as the Geriatric Medicine community) about seriously addressing this "Giant". There is no need to be "humble" Comments to Editor	Thanks – we have been more forthright in the modified text. And we have explicitly referenced Isaacs by way of Morley.	"despite being one of the original "Geriatric Giants"[15], continence has not established a foothold in the mainstream of geriatric medicine in the way that other subspecialties have. Subspecialty posts focusing on continence are rarely funded or advertised. Outside of the work of the ICI, the expertise of geriatricians is frequently not given prominence in guidelines, which focus predominantly on the urogynaecological aspects of care. Our call to arms in this commentary is part of a longstanding trend for

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