**Aims of Workshop**

The aim of the workshop is to share findings from quantitative and qualitative research highlighting the complexity of the global problem of faecal incontinence in nursing homes and to propose a person-centred nursing approach to care that goes beyond the cure paradigm.

**Learning Objectives**

Describe the complexity of the management of faecal incontinence in nursing homes

**Target Audience**

Clinicians, nurses, physiotherapists, geriatricians and scientists interested in conservative management of faecal incontinence in older patients living in nursing homes

**Advanced/Basic**

Intermediate

**Suggested Reading**


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<td>Lene E Blekken</td>
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<td>Joan Ostaszkiewicz, Susan Saga, Lene E Blekken, Sigrid Nakrem</td>
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Understanding faecal incontinence in nursing homes: What is the problem?

Susan Saga

Faecal incontinence in nursing home patients has a multifactorial aetiology. They experience multiple diseases, causing cognitive and physical impairment. They need a lot of help managing activities of daily living, including toileting and bowel management. In addition, anorectal changes related to reduction in internal and external anal sphincter tone and sensation may affect the person’s bowel function and control. A recent systematic review of prevalence and correlates of faecal incontinence in nursing homes shows that more than 40% of patients had faecal incontinence in studies reported after 2015. Older people living in care homes experience more double incontinence compared to isolated faecal incontinence\(^1\). The most commonly reported potentially modifiable correlates of faecal incontinence from the nursing home studies are ADL, diarrhoea, urinary incontinence, constipation, reduced mobility, and the use of laxatives. The most commonly reported non-modifiable correlates to faecal incontinence in nursing homes are older age, gender, dementia and stroke. However, these modifiable and non-modifiable correlates to faecal incontinence in nursing home patients are all linked to factors in individuals. A Norwegian study of prevalence and correlates of faecal incontinence in Nursing homes showed that length of stay in nursing home has a significant contribution to faecal incontinence when adjusted for age, ADL impairment and cognitive impairment, which may partly be measures of frailty\(^2\). The same study also found a significant difference of faecal incontinence prevalence between nursing homes that were otherwise comparable\(^3\). This may indicate that differences in care quality exist and the culture in the nursing homes will impact on whether patients’ needs for adequate continence care are met.

Quantitative and qualitative findings show that faecal incontinence is most often managed passively with pads. A Norwegian study demonstrated that pads were widely used, also as a safety precaution, although it was not always necessary\(^4\). Patients who were continent at admission could end up incontinent for both stool and urine as time passed. Patients gradually got used to defecating in pads, due to both having waited for toileting assistance from staff many times previously, as well as not wanting to bother the staff.

Also, in the Norwegian study, faecal incontinence was not recognised as a significant problem by the staff as opposed to constipation, despite the high prevalence. Emptying bowels was the main concern of the staff and how this was done was less important. Faecal incontinence was also considered “normal” for the patient group, and therefore not subject to further examination, assessment and treatment. Registered nurses also felt alone in decision-making and treatment of these patients. Shortage of time often leads to the completion of only the most essential tasks. This makes it difficult to engage in a meaningful dialogue with the patients regarding their specific needs, and developing and maintaining individualised, person-centred care practices becomes difficult.


Management of faecal incontinence in complex patients in nursing homes.

Lene E Blekken

Persons living in nursing homes are the most fragile of the older patients. A “frail older person” is defined as those over the age of 65 with a clinical presentation or phenotype combining impaired physical activity, balance, muscle strength, motor processing, cognition, nutrition, and endurance (including feeling of fatigue and exhaustion). In addition to these phenotype criteria, many of the patients also have comorbidities and disabilities\(^1\). Altogether this leads to a kind of “double complexity” in the patient group for the health personnel to manage:

1. The individual patients have their unique complex health condition leading to a wide diversity of actual and potential health problems.
2. The complex health condition among the individual patients makes the nursing home population a multifaceted group of patients with a complex set of care needs.

One of the consequences is that the traditional unidimensional care pathways are not effective in this group. The symptom, faecal incontinence is often caused by interplay of interdependent factors in the individual patient. And, as health personnel, you will not succeed in your management of faecal incontinence if you offer the same treatment to the whole group.

In the process of managing faecal incontinence it is necessary to have a broad approach, and it is important that the health personnel have high knowledge and advanced skills when it comes to meeting patients’ needs for assessment, care and treatment. The management of faecal incontinence must begin with an active case finding including a thorough bowel assessment. The assessment leads to a determination on onset, cause and type of faecal incontinence. It is important to remember that in older frail persons the causes are often multiple, e.g. diarrhoea, impaired cognition and toileting self-care.
deficit. The management must then be coherent with the causes in order to match the treatment to the individual patient. Health personnel should, however, consider the degree of bother to the frail older person; the goals of care; whether the patient is able to adhere to the intervention due to, e.g., cognitive or functional impairment; and the overall prognoses and life expectancy. As patients living in nursing homes to a large degree are dependent of care personnel to carry out the interventions, you also need to consider what is possible for care personnel to accomplish.

For most of the frail patients living in nursing homes, faecal incontinence will be one of many health problems. In order to capture a holistic picture of the patients the approach need to involve more than “looking” for faecal incontinence. One possible response for capturing the whole complexity of the person, is ‘Comprehensive Geriatric Assessment’ defined as a: multidisciplinary diagnostic process intended to determine a frail older person’s medical, psychosocial and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up working towards person-centred goals.


Quality improvements in nursing homes
Sigrid Nakrem

In all health organisations, healthcare employees have the challenge of the “two jobs” that they should accomplish: (i) to perform their work, and (ii) to continuously improve quality of care. However, nursing homes, which arguably, can be defined as complex organisations, struggle to reach recognised standards of continence care. Additional challenges nursing home staff face are the complex needs of patients with faecal incontinence, including multi-morbidity, frailty and limited capacity to participate in care, highlighting the diversity of patients with faecal incontinence. Traditional approaches to clinical improvements in continence care often include rigid methodology to measure effects, e.g. Randomised Controlled Trials. However, often these approaches fail for two reasons. First, since it might be difficult to measure effects of interventions in complex organisations, little new evidence to what constitutes effective care is therefore added. Second, such research studies do not offer learning opportunities for staff and nursing home organisations since implementation of new knowledge takes time and need to be adapted to the context to have effect. By viewing nursing homes as a complex rather than a mechanical system, the properties of complex adaptive organisations can be used to support quality improvements in continence care, and mechanistic confidence in standardised care can be avoided.

In this presentation a more flexible approach to accommodate to the unpredictability and variety of nursing home patients and contexts will be suggested, including:

- Understanding complex organisations with its characteristics that include nonlinear interactions of organisational components, emergent, self-organized behaviour, and the dependence on simple rules
- Adapting to multi-disciplinary patient needs, the multitude of processes, and routines that need to be considered simultaneously
- Highlighting barriers that need to be taken into consideration to adopt system learning and improving continence care in nursing homes

A recommended response to the need to accommodate complexity when implementing quality improvement activities is to adopt Plan-Do-Study-Act-processes (PDSA). This approach can assist care teams to participate and take ownership, reflect on and experientially learn from activities they initiate and organise themselves to improve care. In addition, by starting with smaller scale projects and allowing improvement efforts to be adjusted along the way, a person-centred approach that consider complexity in both the individual patient and the context can be ensured. However, most nursing homes and staff have little new evidence to what constitutes effective care is therefore added. Second, such research studies do not offer learning opportunities for staff and nursing home organisations since implementation of new knowledge takes time and need to be adapted to the context to have effect. By viewing nursing homes as a complex rather than a mechanical system, the properties of complex adaptive organisations can be used to support quality improvements in continence care, and mechanistic confidence in standardised care can be avoided.


Reframing continence care in nursing homes to accommodate context
Joan Ostaszkiewicz

A longstanding problem is the high prevalence and acceptance of urinary and faecal incontinence in nursing homes. Incontinence is a biological, personal, social and cultural phenomenon. Current guidelines for the management of faecal
incontinence in nursing homes emphasise multidisciplinary screening and assessment processes to identify potentially treatable causes, followed by pharmacological treatments, toileting assistance programs and dietary interventions, as well as education to staff to heighten their awareness of the problem. However, translating these guidelines into practice is a considerable challenge. Over forty years ago, researchers claimed the care of people with incontinence in nursing homes was characterised by therapeutic nihilism. Incontinence continues to be viewed as a normal part of aging and is normalised in nursing homes. Compared with efforts to minimise restraint use or to prevent pressure injuries, efforts to reduce incontinence in nursing homes with proactive, evidence-based treatment strategies focused on maintaining and restoring continence have had limited successful. Why? We suggest that part of the problem is that current solutions do not accommodate the complexity of the environment and do not resonate with nursing home staff.

Quantitative and qualitative research illuminates the complexity of preventing and managing incontinence in nursing homes. It reveals:

- A highly vulnerable population of very elderly people with a limited-life expectancy
- High rates of behavioural and psychological symptoms of dementia that complicate continence caregiving, making it a behavioural problem for staff
- Staffing levels that do not adequately resource homes to consistently address the older person’s fundamental care needs, (eating, elimination, hygiene) leading to pragmatic staff decisions that accommodate under resourcing
- A risk adverse environment and fear of litigation
- Low social status of nursing home care work and care workers
- A socio-cultural environment that places care-dependent older people with incontinence at risk of coercion, verbal and physical abuse and neglect

Unilateral continence interventions may not accommodate this complexity or resonate with the key stakeholders. Qualitative research reveals dignity resonates with nursing home staff as a key goal of care, rather than cure, improvement or prevention. Indeed, staff equate good continence care with activities that they believe will protect older peoples’ dignity. Hence, the researcher suggests efforts to improve the quality continence care in nursing homes should build on and extend aged care staff members’ understandings about what constitutes dignity in continence care so that it is based on the older person’s preferences, beliefs and goals.

Understanding faecal incontinence in nursing homes: What is the problem?

Susan Saga, PhD, MSc, RN

Prevalence of FI in nursing homes – a systematic review (Musa et al 2019)

The included studies (23) showed:
• Median of FI 42.8%
• Median of Isolated FI (patients with FI only and no urinary incontinence) 3.5%
• Older studies reported a lower prevalence of FI compared with recent studies
• More than 40% of residents had FI in studies reported after 2015

Characteristics of nursing home patients

• Frail elderly patients
• Multi-morbidity
• Physically impaired
• Cognitively impaired

Comprehensive care needs

• They need a lot of help managing activities of daily living such as:
  • Dressing
  • Grooming
  • Walking up stairs
  • Feeding
  • Toileting and bowel management

Anorectal function and control in healthy older adults – ICI 2017 (Saga et al 2017)

• Reduction in squeeze pressure
• Reduction in resting pressure
• Decrease in rectal sensory thresholds
• Changes in the gut thresholds in older adults in long-term care settings

Modifiable correlates of FI in nursing homes – a systematic review (Musa et al 2019)

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Note: = statistically significant correlate; No = not statistically significant; ADL = activities of daily living; UI = urinary incontinence; Blank spaces = not measured
Non-modifiable correlates of FI in nursing homes – a systematic review (Musa et al 2019)

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Yes = statistically significant correlate; No = not statistically significant; F = female; M = male; Blue colour = protective effect; blank spaces = not measured

Bliss 2013
Carrey 2017
Blekken 2016
Ihnat 2016
Jerez 2015
Mandl 2015
Saga 2015
Bliss 2013
Aslan 2009
Wang 2009
Harrington 2008
Rodrigue 2007
Nelson 2005
Chiang 2000
Chassanger 1999
Nelson 1998
Johanson 1997
Peet 1995
Kinnunen 1991
Burgio 1988
Thomas 1987
Capewell 1986
Tobin 1986

Individual or Institutional factors?

Length of stay in nursing home associated with incontinence (Saga et al 2013, Saga et al 2015)

Differences in prevalence of both FI and UI between nursing homes that were otherwise comparable – difference in quality of care and in care culture? (Saga et al 2013)

Interventions for patients with FI (Saga et al 2014)

• Incontinence pads (88.9%)
• Fixed toilet schedules (38.6%)
• No interventions were carried out for 11.1% of the patients with faecal incontinence

“Unfortunately, I usually say that if people do not use pads when they come to us, just give us a month or two. Then they have become pad users for both one and the other [urine and feces]. […] It becomes a habit to be sitting with a pad.”

(Informant working in a nursing home)

Challenges in bowel management in nursing homes… (Saga et al 2014)

Task oriented care
Patients’ toilet needs were inadequately met
FI was mainly treated passively with pads
FI was considered “normal” in nursing home patients
Poor interdisciplinary collaboration

Conclusion FI in nursing homes

A gap between patients’ need and care given
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W7: Complex patients in complex organisations: Implications for continence care for people with faecal incontinence living in nursing homes

Understanding faecal incontinence in nursing homes: What is the problem? Susan Saga

Management of faecal incontinence in complex patients in nursing homes Lene E Blekken

Quality improvements in nursing homes Sigrid Nakrem

Reframing continence care in nursing homes to accommodate context Joan Ostaszewicz

Handout for all workshops is available via the ICS app, USB stick and website.

Please silence all mobile phones

PDF versions of the slides (where approved) will be made available after the meeting via the ICS website so please keep taking photos and video to a minimum.

Please complete the in-app evaluation in the workshop before leaving.

Management of faecal incontinence in complex patients in nursing homes.

Dr. Lene Elisabeth Blekken
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Affiliations to disclose:
No financial ties

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☐ Institution (non-industry) funded
☐ Sponsored by:

*Note: Please disclose any financial or non-financial relationships with business organisations with respect to the subject being discussed in this presentation.
People living in nursing homes are the most vulnerable of all older people

Frailty = complexity

A frail older person:

- Those over the age of 65 with a clinical presentation or phenotype combining impaired physical activity, balance, muscle strength, motor processing, cognition, nutrition, and endurance.
- Many also have comorbidities and disabilities (Wagg et al. 2017)

Each individual resident has their own unique complex health condition leading to a wide diversity of actual and potential health problems.

The complex health conditions among the individual resident makes the nursing home population a multifaceted group of individuals with a complex set of care needs for health personnel to manage.

One of the consequences – traditional unidimensional care pathways are not effective in this group

Because of the more or less complex health conditions...

Faecal incontinence

One possible health problem with a high prevalence

... faecal incontinence is often caused by an interplay of interdependent factors in the individual patient

... as health personnel you will not succeed in your management if you offer the same treatment to the whole group

Management

1. Active case finding including a thorough bowel assessment.
2. The assessment leads to a determination on onset, cause and type of faecal incontinence. It is important to remember that in older frail persons the causes are often multiple.
3. The management must then be coherent with the causes in order to match the treatment to the individual patient.

(Blekken et al. 2018, Wagg et al. 2017)

Exemplar guideline for bowel assessment

Exemplar guideline on diagnostic assessment and management
Exemplar guideline for patient outcomes

Consider the degree of bother to the frail older person, whether the patient is able to adhere to the intervention and the overall prognoses and life expectancy.

- As patients living in nursing homes to a large degree are dependent of care personnel to carry out the interventions, you also need to consider what is possible for care personnel to accomplish.

Patient outcomes to consider:
- Subjective degree of bother
- Physical health problems
- Quality of life
- Ability to adhere to the intervention
- Prognoses and life expectancy

Because faecal incontinence is only one of many possible health problems...

Comprehensive geriatric assessment
A multidisciplinary diagnostic process intended to determine a frail older person’s medical, psychosocial and functional capabilities and limitations in order to develop an overall plan for treatment and long-term follow-up working towards person-centred goals.

(Chadborn et al 2019)

Thank you for your attention

Quality improvements in nursing homes
Prof. Sigrid Nakrem, RN, MSc, PhD
Department of Public Health and Nursing
Norwegian University of Science and Technology NTNU
Norway

References

Why is implementing good FI care in nursing homes so hard?

‘The two jobs’ competing: performing the job and continuously improving quality of care (Nakrem et al, 2019; Seers et al, 2018)

Evidence of what constitutes good FI care is lacking or not available for clinical staff (Hahman et al 2012)

Lack of competence and skills among staff and leaders (Nakrem et al, 2019; Kuipers, 2011)

Underresourced sector (Sullivan et al, 2013, Rahman et al, 2012)

Applying complexity science in NHs

Florence Nightingale – ‘the lady with the Data’

Caring for nursing home residents is complex (Clegg et al, 2013)

Everyone in the health care system contributes to quality and safety (Ginsburg et al, 2018)

Culture and outcomes are linked (Braithwaite, 2018, Kuipers et al, 2011, Nakrem 2015)

Improving quality means addressing what matters to patients (Suhonen et al, 2009)

Using the right improvement tools and methods matters (McGaffigan, 2019, Sullivan, 2013, Kuipers et al, 2011)

Understanding data is essential for improvement (Lipsitz, 2012, Rahman et al, 2012)

Complex organisations

‘Change is the only constant’ (proverb more than 2000 years ago)

Complicated, complex or chaotic?

‘Medicine and healthcare used to be simple, ineffective and relatively safe. Today it is complex, efficient and potentially dangerous.’ (Chantler, 1999)

Complexity is related to:

- Multi-component interactions
- Non-linearity
- Emergent, self-organized behaviour
- Organisational unpredictability and complex patients (Lipsitz, 2012)

Plan-Do-Study-Act  

Understanding Commitment Facilitation

Valid measures of change

Act

Initialize

Evidence-based practice

Study

Plan

Do

The nursing home context

Process-oriented improvement strategy

- Test solutions at small scales before implementation
- Involve all stakeholders
- Refine and test additional solutions
- Conduct multiple tests and processes simultaneously

Conclusions

Nursing homes are complex health care organisations: Improvement projects should not be too complicated (Baldoza, 2019).

Empower staff to take ownership of quality improvements

Leadership and organisational culture might be major barriers, causing resistance

Value small-scale projects: ‘Do not confuse slow and small change with no change’

(Hans Roeling, 2018)

References

• Baldoza, K. (2019). Do We Make QI Too Complicated? http://www.ihi.org
• Nakrem, S. et al. (2019). Staff experiences with implementing a case conferencing care model in nursing homes: a focus group study. BJHM: Health and Social Care in the Community, 27:450-457
• Rahman, A. N. et al. (2012). Translating research into practice in nursing homes: Can we close the gap? The Gerontologist, 52(5):597
• Suhonen, P. J. et al. (2010). The key problems

The key problems

• Underdiagnosis and undertreatment
• Toileting assistance at rates that do not optimise physiological autonomy or continence
• Overreliance on incontinence products - 92%

ICF recommendations for continence care in frail older adults

Multidisciplinary screening, assessment and treatment to identify and treat potentially reversible causes and initial conservative interventions to prevent, minimise and/or treat incontinence

(Williams et al., 2017)

Initial conservative interventions

• Lifestyle modification interventions
• Pelvic Floor Muscle Training.
• Weighted Vaginal Cones and Pessaries.
• Electrical Stimulation.
• Posterior Tibial Nerve Stimulation.
• Magnetic Stimulation.
• Complementary and Alternative Medicines.
• Scheduled Voiding Regimens

Incontinence products

Environmental changes

Attention to functional skills

Education and awareness raising

W7: Complex patients in complex organisations: Implications for continence care for people with faecal incontinence living in nursing homes

Reframing continence care in nursing homes to accommodate context

Dr. Joan Ostaszkwicz, RN, MNurs-Res, PhD
The Institute for Health Transformation
Deakin University
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Essity – travel fees 2018 /consultant fees 2019
Unicharm – consultant fees 2017

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☐ Self-funded
☐ Institution (non-industry) funded
☐ Sponsored by:

The key problems

• Underdiagnosis and undertreatment
• Toileting assistance at rates that do not optimise physiological autonomy or continence
• Overreliance on incontinence products - 92%
Nursing home contextual factors

- Resident characteristics
- The nursing home workforce
- Community expectations
- The availability of medical care
- Staffing levels
- The organisational culture
- The social status of nursing home employees and their work
- The regulatory environment

Resident characteristics: Australia

- 82 yrs for men, 85 yrs for women
- 35 mths average length of stay
- 58% have high care needs related to ADLS
- 53% have complex health care needs
  (Commonwealth of Australia 2017-2018)
- Poor prognosis:
  - 23% die within a twelve mth period
  (Theo et al., 2013)
  - Increased continence care needs in last 24 mths
  of life (Covinski et al 2003)

High rates of behavioural and psychological symptoms of dementia

- 61% have high care needs related to behaviours
  (Commonwealth of Australia 2017-2018)

The nursing home workforce: Australia

- 235,764 employees
- 153,854 provide direct care
- 87% female
- Median age 46 years
- 70% Personal Care Attendants
- 32% born overseas
- A part time and casual workforce

Community expectations

Increased expectations for relation-oriented care rather than task-oriented care.

Various obstacles, needs and competences need to be addressed in order to successfully facilitate this change

(McSheehy et al., 2017)

Medical care

Agotes et al., 2109. An international mapping of medical care in nursing homes in Canada, USA, Norway, Germany, USA.
Staff numbers and skill mix

Staffing and time required for toileting assistance

- 1-person assist \(11 \text{ min} \times 5 = 55 \text{ min in 24 hrs}\)
- 2-person assist \(25 \text{ min} \times 5 = 125 \text{ min in 24 hrs}\)
- A lifting machine \(33 \text{ min} \times 5 = 165 \text{ min in 24 hrs}\)

(Thomas et al., 2015)

Low staffing in nursing homes makes incontinence a largely socially engineered phenomenon.

Many nursing home residents struggle to maintain ‘physiological autonomy’ (Sacco-Peterson & Borell 2004).

The organisational culture

- NHs like all organisations have certain patterns of structure, cultural assumptions and interactions i.e. conforming and differentiating features (Nakrem 2015)
- 4 typologies identified; (i) residency oriented, (ii) medical oriented, (iii) safeguard oriented, (iv) family oriented (Nakrem 2015)
- 62 studies show improving culture improves patient outcomes, but these are localised solutions (Braithwaite 2017).
- Nursing leadership is critical to quality care
  - Association b/t positive relational leadership styles and higher patient satisfaction and lower patient mortality, medication errors, restraint use and HAIs
  - Mechanism of influence is unclear (Wong 2013)

The social status of nursing home employees and their work

- Low occupational status
- Vulnerable to courtesy stigma
- Low wages relative to other areas within nursing and healthcare
- Low educational levels (Ostaszkiewicz 2014)

The regulatory environment

- Fear of litigation/failing standards
- Prioritisation of falls prevention strategies
- Focus on compliance and checklists
- Duty of care to protect versus right to self-determination – risk of coercion, abuse or neglect (Ostaszkiewicz et al., 2016)

Coercive or abusive continence care practices

- Chastising a person for incontinence
- Overriding a person’s attempts to resist continence care

Neglect in continence care

- Withholding or delaying responding to requests for help to maintain continence or to manage incontinence.
- Restricting a person’s access to toileting assistance or containment products (Ostaszkiewicz 2017)

The Dignity in Continence Care Framework

Dignity and care
- A foundational and person-centred continence assessment
- Empathic continence care
- Personhood in dementia
- Therapeutic communication
- Authentic partnership with NOK in continence care
- Acknowledging stigma, social taboos and courtesy stigma

We have to keep their dignity
• Test solutions at small scales before implementation
• Involve all stakeholders
• Refine and test additional solutions
• Conduct multiple tests and processes simultaneously
• Avoid relying on a linear cause-effect - accept unpredictability
• Attempt to understand how things work at a local level (interactions and effects)
• Accept the default position: avoid (do not misconstrue as resistance)
• Promote emergent spontaneous change from within at a local level
• Emphasise principles, boundaries, resources
• Ensure effective feedback mechanisms to allow solutions to be shared (Tufin, 2016)

References

G. Association between organisational and workplace cultures, and patient outcomes: a systematic review. BMJ Open. 2017;7:e017708

Key messages

• Aim for person-centred continence care
• Look beyond the bowel
• Involve people in decisions that affect them
• Provide feedback to nudge systems behaviour out of equilibrium, thereby building momentum for change
• Begin with small scale initiatives and build up and be flexible
• Understand the context – avoid blame