What can we do to improve the patient experience of continence care?

Sharon Holroyd

Incontinence can affect people of all ages and genders and can have devastating psychological, social and financial implications for the individual and his or her family. Many people may fail to seek help with incontinence for years due to embarrassment and stigma, which in turn can lead to social isolation. The prevalence of bladder and bowel incontinence is increasing worldwide, in part due to an ageing population — more people are being looked after in residential and nursing homes than ever before and admissions to acute care due to incontinence-associated conditions have increased. All of these factors increase the burden of care on health and social care staff, potentially leading to a lack of quality services. Dignity is internationally accepted as a fundamental human right, yet a host of public inquiries (such as the Francis Report [2013] in the UK) repeatedly raise the issue of failure to respect patient’s dignity, particularly in relation to continence care. This article explores why continence care causes such complicated issues and how community nurses can help to ensure it is seen as an essential element of care, rather than being dismissed as only requiring basic skills.

KEYWORDS:
Continence ■ Staff skills ■ Urinary incontinence ■ Bowel health

Incontinence is defined as any involuntary loss of urine or the inability to control the bowels (International Continence Society [ICS], 2013). While it is not seen as a life-threatening condition, it does have a significant and distressing effect on the physical, psychological and social quality of life of those affected (Lukacz et al, 2011). Isolation, anxiety, depression and embarrassment are commonly reported by people who have a bladder or bowel issue (Wan and Wang, 2014).

Appropriate recognition and assessment of incontinence will lead to a better awareness, while education of staff, public and patients will help to break some of the social taboos. The ‘right treatment at the right time by the right service’ will lead to an improved patient experience and outcome, as well as reduced costs to healthcare services.

‘BASIC’ OR ‘ESSENTIAL’ CARE?

Urinary incontinence is more common than breast cancer, heart disease or diabetes among older women (Sexton et al, 2011; Tannenbaum et al, 2013), yet it still does not figure as a priority on many national health agendas, often being described as involving basic rather than essential care (Palmer et al, 2012). However, by referring to continence care as basic, has the healthcare community been guilty of diminishing the importance of appropriate and adequate care?

The Francis Report (2013) is only one example of recent high-profile investigations that have highlighted the appalling consequences for patients who receive inadequate management of their continence needs.

Yet, continence care is still not seen as a priority by the majority of healthcare workers (Tomlin, 2013). The NMC standards for pre-registration nurse education (2010) includes five essential skills clusters — none of which have any significant detail on the management of continence.

All children are taught to control their bladder and bowel and acquiring these skills at pre-school age has become even more important in recent years, with many children attending nurseries as babies or ‘toddlers’.

Parents are fearful that their child might be the only one still using nappies in nursery or school, and everyone can relate to the acute embarrassment of a child who has an ‘accident’.

Stigma

Socially, continence is not a topic that is commonly discussed and then

Uncontrolled diarrhoea can cause dehydration, gradually draining the body of the fluids it needs to function properly. Dehydration is particularly dangerous in children and older people, and must be treated quickly to avoid serious health complications.

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Faecal incontinence is an inability to control bowel movements, resulting in the involuntary passage of stools. The most common causes are:

- Rectal problems: severe constipation (resulting in overflow diarrhoea) or diarrhoea itself mean that stools cannot be retained properly
- Sphincter muscles: events such as childbirth can damage the muscles at the base of the rectum
- Nerves: nerve damage through conditions such as diabetes or multiple sclerosis may mean that nerve signals sent from the rectum may not reach the brain in time.

Source: NHS Choices: www.nhs.uk

In some situations, feeling exposed through open toilet doors or during medical examinations can affect a person’s dignity, in turn leading to increased feelings of vulnerability, dependence on others, and a lack of control over the environment or events (Booth, 2013).

What’s going wrong?

It is important for community nurses to constantly ask whether the continence care they are providing is evidence-based and effective. For example, while lack of resources and low numbers of qualified staff might be valid reasons for inadequate care in some situations, they should not be used as an excuse.

A study by Orrell et al (2013) sought views from 16 continence services in England and identified issues with education, negative attitudes, poor referral pathways, and weak collaborative working partnerships with other organisations, all of which have a significant impact on the experience of the patient with a continence issue.

Similarly, attitudes are not always helpful — for instance, some nurses believe that incontinence is inevitable in the older person who is being ‘looked after’ in social care facilities and may be reliant on intermittent visits from GPs or district nurses (Nazarko, 2001; Orrell et al, 2013; Vickerman, 2014).

Documents such as the The NHS Five Year Forward View (NHS England, 2014) highlight how social and health care are increasingly expected to overlap in today’s society, and continence issues are an important consideration for staff who work in either environment.

Moving from basic to essential

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Answer the following questions about this topic, either to test the new knowledge you have gained or to form part of your ongoing practice development portfolio.

1 – What are the common symptoms of urinary incontinence?
2 – Can you identify why continence issues involve so much social stigma?
3 – What are the most common causes of faecal incontinence?
4 – What are some of the key elements in an assessment for incontinence?
5 – Why is incontinence education so important for community nurses in the future?

between staff from a variety of organisations will also help to improve patients’ quality of life (Goodman et al, 2013). For example, this might involve an NHS continence service liaising with a manufacturer of containment devices to ensure patients receive a full assessment of their needs, a robust plan of care and the correct products.

Culture

A study by Agnew and Booth (2013) highlighted that non-specialist nurses often did not believe they had the authority to actively promote continence and instead relied on containment methods such as pads, indwelling catheters and penile sheaths.

This reflects a nursing culture that for too long has advocated these methods as standard, first-choice treatments, rather than adopting a patient-centred approach that might, for example involve a frequency/volume chart or bladder/bowel diary and a simple medication review before referring the patient onto a more specialist service (Royal College of Physicians [RCP], 2014).

Assessment

While management methods such as pads and sheaths have a place, a robust personalised assessment of each patient is essential when planning treatment for patients with incontinence.

The assessment should be carried out by a specialist service with appropriately trained/experienced staff. Bladder and bowel function can be improved with a personalised treatment plan in many patients and nurses should focus on promoting continence rather than managing incontinence (Booth, 2013).

Assessment must also consider functional ability (Vickerman, 2014). The evidence shows that the prevalence of incontinence is much higher in the older age groups (Dubeau et al, 2009; Thirugnanasothy, 2010; Day et al, 2014), therefore it is important to determine whether a bladder or bowel issue is being caused by physiology or a mobility/dexterity problem.

A standardised assessment process that includes comprehensive history-taking, of urinary tract pathology is a key component in identifying people who may develop continence issues (Bedoya-Ronga and Currie, 2014). People experiencing incontinence have often managed the problem themselves for years before seeking help and routine enquiries by community nurses and GPs for example, could lead to earlier detection and treatment, which in turn will improve quality of life.

Referral

Community nurses and staff in residential and nursing homes play a vital part in ensuring that symptoms — such as frequent urination, urgency urination, overflow diarrhoea and abdominal bloating — are recognised at an early stage and appropriate referrals are made.

Introducing a quality structured assessment tool, such as ‘essence of care’ (Department of Health [DH], 2010), to plan patients’ management will lead to the establishment of referral pathways that can help community staff direct patients to specialist services.

Encouraging and promoting shared care, decision-making and partnerships

This is a timely, highly relevant and interesting article focusing on the important role of community nurses in managing bladder and bowel care for the patients in their care.

The author examines the evidence, recent documents and current thinking in respect of the way forward in continence care and looks at issues around patient dignity, access to continence education for healthcare professionals, as well as the current shift to providing care closer to people’s homes and the impact that will have on community nursing.

It is clear that despite advances in many aspects of health care, significant problems remain in respect of quality bladder and bowel care.

The author emphasises the important point that it is vital for continence care to be seen as ‘essential’ as opposed to ‘basic’. Attitudes and priorities need to change for this to happen.

This article is an excellent resource for all community nurses caring for patients with bladder or bowel problems in helping to improve the overall patient experience.

Expert commentary

Janice Reid, continence services manager, Western Health and Social Care Trust, Londonderry

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patient’s perception of his or her symptoms and the effect on quality of life is essential (National Institute for Health and Care Excellence [NICE], 2013).

Any physical assessment should include a urine dipstick test to eliminate potential infections, although this must not be used as a stand-alone diagnostic tool for urinary tract infections (UTIs) — rather dipstick tests should be used as an indicator that further investigations may be required (European Urology Association [EAU], 2013).

This issue is currently being addressed by NICE who are close to publishing new quality standards to accompany the current incontinence guidelines (NICE, 2013; 2014).

Essential components of a physical assessment should also include (NICE, 2013):

- A post-void bladder scan to check residual volumes of urine — elevated post-void residual urine (PVR) increases the risk of UTI and is an indicator of lower urinary tract dysfunction (EAU, 2013)
- Abdominal examination to exclude any suspicion of palpable faecal mass
- Examination of the genital area for atrophy, soreness, and/or prolapse
- Digital examination in both males and females to check the pelvic floor muscle tone and ability to ‘contract’ effectively — contracting the pelvic floor muscles is crucial to being able to withhold urine and faeces
- Bladder and bowel diaries completed by patients over three days can provide community nurses with a functional assessment of ‘real-time’ continence issues, e.g. how often they go to the toilet; do they have trouble going to the toilet, etc.

Education
Lack of education has been identified as a key area for improvement in continence issues. McClurg et al (2013) carried out a survey of 84 UK universities that showed there had been no change in dedicated time for continence education over a 17-year period. This was despite several national audits of continence care highlighting inadequate training (RCP, 2006; 2010). Similarly, a 2009 report by Lomas showed that almost 53% of qualified nurses did not receive any post-registration continence education.

Subsequent poor standards of continence care highlighted in the Francis Report (2013) can surely be attributed in part to this lack of focus on continence training and education.

Encouraging healthcare organisations to make continence a high priority and including some form of mandatory training would help to ensure continence is viewed as ‘essential’ and not simply a basic element of care that is easily forgotten.

Similarly, if community nurses were to actively seek partnerships with charities such as the Bladder and Bowel Foundation and the Cystitis and Overactive Bladder Foundation UK, this might help to

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educate people with incontinence, breaking down social restrictions and encouraging them to seek help, adopt self-management strategies and eventually improve outcomes (Day et al, 2014).

CONCLUSION

Although the evidence shows that a large number of older adults experience incontinence, patient assessment and continence promotion is key to improving services, irrespective of age.

Rather than regarding continence services as pad providers, more clinicians should focus on recognising continence issues in their everyday patient visits and performing appropriate and timely referrals to specialist continence services — this will lead to an improvement in standards and quality of care (Orrell et al, 2013).

With the current emphasis on providing care ‘closer to home’ (DH, 2009), it is essential to recognise the role community nurses, GPs and other community health and social care workers must play in providing good quality continence care.

Appropriate recognition and assessment of patients’ incontinence needs will also lead to a better awareness among staff, public and patients, and will help to shatter social taboos.

The right treatment at the right time by the right service will improve patients’ experiences as well as reducing the cost to healthcare services.

REFERENCES


KEY POINTS

- Incontinence can affect people of all ages and genders and can have devastating psychological, social and financial implications for the individual.

- Many people may fail to seek help with incontinence for years due to embarrassment and stigma, which in turn can lead to social isolation.

- The prevalence of bladder and bowel incontinence is increasing worldwide, in part due to an ageing population.

- More people are being looked after in residential and nursing homes than ever before and admissions to acute care due to incontinence-associated conditions have increased.

- All of these factors increase the burden of care on health and social care staff, potentially leading to a lack of quality services.

- This article explores why continence care causes such complicated issues and how community nurses can help to ensure it is seen as an essential element of care, rather than being dismissed as only requiring basic skills.

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