Continence care is every nurse’s business

Respect for dignity is a fundamental human right at the forefront of UK and European governmental health and social care policies. The principle is a priority for every working group and parliamentary committee and each document they produce reflects the key purpose of protecting us all from “inhumane or degrading treatment”.

So why does the failure to respect dignity feature so highly in every public inquiry and complaint investigation?

The “appalling suffering of many patients” described in the report of the Mid Staffordshire Foundation Trust public inquiry was largely due to a tolerance of poor standards and a lack of leadership in tackling negative culture (Francis, 2013).

Sentinel indicators of overall quality of care

A major contributor to a person’s sense of dignity is maintaining continence and appropriate toileting. As children, we attain control of our bladder and bowels and, in doing so, learn that bladder and bowel elimination are activities to be undertaken independently, in private, behind closed, locked doors.

Toilet-related activities are rarely discussed and are a source of embarrassment.
often coped with through the use of humour. Objectively this could be seen as unusual: every one of us, regardless of status, will use the toilet several times a day, yet discussing the details of our toileterelated behaviour remains a taboo subject. Nurses, therefore, need to demonstrate high sensitivity to effectively identify and manage continence needs.

Admission to hospital strips people of their sense of self and causes even usually confident people to feel vulnerable. This happens not only as a result of illness, pain and disability, but of an unfamiliar environment and the many unwritten rules and rituals found in hospitals and their individual cultures. The loss of personal autonomy associated with being subject to medical examination and treatment and the authority of the professionals in the clinical environment increases this sense of vulnerability and dependency.

In this situation, respect for dignity is of heightened importance but, paradoxically, it is at its most fragile and easily breached. Simple events, such as bodily exposure or a failure to ensure individual privacy, may contravene dignified care and have a devastating impact on the patients concerned and their families.

Continence is arguably the biggest threat to individual dignity, and the ability to maintain bladder and bowel continence is an elemental part of who we are.

**BOX 1. IMPLICATIONS FOR PRACTICE**

- **Cultural change is essential to recognise** that bladder and bowel care are important and not of a lower priority than other aspects of fundamental care.
- **Education should focus on fostering** comprehension among all staff about what it means to depend on others for continence needs, and the differences between promoting continence and containing incontinence for the person.
- **Realistic educational preparation of all nursing staff** (registered, student and HCAs) is crucial to support and maintain continence. It should include conservative interventions such as lifestyle adjustments, voiding programmes, bladder training and pelvic floor muscle exercises to avoid relying on containing incontinence using absorbent pads and indwelling catheters.
- **There is a need to challenge** entrenched beliefs about incontinence among nurses. Providing excellent continence care is complex and skilled work, which is impossible to do well without good empathy, knowledge and skills that are regularly reviewed and updated.
- **Strong clinical leaders are central to enabling the development of excellent continence care and sustaining it in the long term**.

Responding to requests for assistance sensitively and with respect and compassion for the individual’s needs is often considered to be “just basic care” but getting it right consistently involves a level of emotional intelligence it appears some nurses have not developed (Francis, 2010). For this reason, the government’s response to Francis (2013) is disappointing.

**Why does continence care go wrong?**

The reasons behind inadequate continence care are complex and multifaceted and we should not jump to obvious conclusions without considering the broader view.

A lack of resources in terms of numbers of nursing staff is a frequent complaint (Dingwall and McLafferty, 2006) together with inadequate toilet facilities and not enough time for using hoists and other moving and handling aids. It is vital that we acknowledge these factors as major contributors to the challenges facing nurses in providing good continence care.

**Education**

Another key reason for the acceptance of poor continence practice is a lack of education in the management of bladder and bowel dysfunction and continence promotion. National audits of continence care have repeatedly highlighted inadequate professional education as a cause of substandard practice (Royal College of Physicians, 2010; 2006).

A recent survey of 84 universities in the UK (McClurg et al, 2013) demonstrated that the content of and allocated time for undergraduate continence education has not changed in the past 17 years. This is despite the increasing prevalence of incontinence, the escalating reports of inadequate quality of continence care and higher demands for continence-related intervention, as well as the increasing complexity of treatment approaches. Adult nurses received an average of 7.3 hours of continence-related education throughout their undergraduate programme and for the vast majority this is integrated into other modules, rather than delivered as a separate continence module.

This lack of specific focus may partly explain continued poor standards and the apparent failure to make progress, particularly as 53% of qualified nurses report receiving no continence education after registration (Lomas, 2009).

**Skill mix**

In light of these findings, McClurg et al (2013) call for the development of core competencies for undergraduate education in continence care to be agreed and innovative methods of teaching developed. The findings of the Francis reports (2013; 2010) are testament to this need and yet fail to go further and recommend the inclusion of continence training for healthcare support workers. This is crucial to high-quality standards because HCAs deliver the majority of frontline continence care.

The increased reliance on HCAs is a further consideration in the complexity surrounding continence care, as they have replaced nurses in many teams. This downward slide of skill mix has been blamed for failings in care in situations including Mid Staffs, as it results in those with the least training (or indeed no training) delivering the majority of direct continence care. However, it may be
equally argued that nurses have not seen continence care as a priority (Booth et al, 2009) and tended to distance themselves from elimination activities, which are considered to be “dirty work” to be given to the lowest-status, lowest-paid workers – HCAs (Jervis, 2008).

Reactive care
Toilet-related care is, by its nature, reactive and unpredictable, usually only happening when a patient calls for assistance. Because such continence care needs tend to interrupt other planned activities, they are often seen as a nuisance, which may explain why requests for assistance to use the toilet are ignored, or patients are left on commodes or in the toilet for far too long (Francis, 2010). In view of the Mid-Staffs inquiry, it is perhaps no longer acceptable for nurses to abrogate their responsibilities for continence care to HCAs.

Recommendations for practice
There is a universal need for improved continence care in the NHS, which registered nurses should respond to and lead, monitoring progress in order to provide dignified care that enables dependent patients, especially older people, to maintain or regain continence.

However, registered nurses need education and support to achieve this stepped change in culture and practice. This was evidenced in a recent unpublished study exploring nurses’ intentions towards managing urinary incontinence following stroke (Agnew and Booth, 2012). The findings showed that nurses did not perceive they had the authority to implement programmes of nursing to actively promote continence and instead relied on routine practices involving containment of leakage to manage the patients’ incontinence. The study showed how essential nurses’ beliefs are to the ultimate standard of continence care they provide.

Interpreting the findings in light of the Francis recommendations leads to the conclusion that educational processes need to change to alter nurses’ perceptions of continence promotion and recovery of bladder and bowel function. However, this will require a shift in culture, as continence care in the past has been synonymous with “containment”, usually using absorbent pads but also through the use of indwelling urethral or sheath catheters (Cowey et al, 2012). To achieve such a fundamental change, there will need to be an in-depth examination of continence practices and values and a willingness to examine what can be seen as part of the bedrock of nursing.

Perhaps we need to return to first principles of doing the patient no harm and pay more attention to developing our understanding of what it is we seek to do – promote continence or manage incontinence? There is a fundamental difference between the two and it is essential that we now debate if we are to progress our practice to benefit patients in all fields of nursing.

Conclusion
Continence care is an essential part of nursing and care, and nurses need to acknowledge this and refocus efforts to demonstrate an improved quality of continence care.

The Francis recommendation to focus on the culture of caring highlights the need to increase the focus in nurse training, education and professional development on the practical requirements of delivering compassionate care and show that they are putting patients’ needs first.

References