Practitioner suggestions for improving continence care in hospitals

Keywords Hospital nurses/Continence care/Toileting and independence

In this article...
- Factors that help or hinder good continence care
- Why overuse of pads and catheters can have detrimental effects
- How regular continence training for healthcare staff would promote better care

Key points
- Continence is a big healthcare issue, with more than 14 million people in the UK affected
- Good-quality continence care encourages patient independence
- Talking in a matter-of-fact way with patients about incontinence can help overcome embarrassment
- Overuse of pads and catheters creates dependency, jeopardises patient skin integrity and puts patients at risk of infection
- Nursing and medical staff want regular, evidence-based, trust-led continence training

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Abstract Difficulties with bladder control affect one in five people in the UK and bowel problems affect one in ten. The quality of continence care can be poor and is then associated with increased admission to nursing or residential homes. Our study, which is summarised in this article, set out to identify factors that help and hinder good continence care for patients aged ≥65 years in hospital medical ward settings. We carried out 27 face-to-face interviews with nursing, medical and allied health practitioners in three hospitals. Examples of good-quality care included person-centred care that encouraged independence; poor-quality care resulted from over-reliance on products, such as pads or catheters, with an associated risk of infections. Practitioners suggested that continence care could be improved through open communication with patients, conservative treatments and regular continence care training.


More than 14 million adults in the UK experience uncontrolled loss of urine and 6.5 million have difficulties with bowel control (NHS England, 2018). Incontinence affects all age groups and is more common than heart disease, breast cancer or diabetes among older women, but it has a low public-health profile and is not given the attention it deserves (Holroyd, 2015).

Continence care has a major impact on individuals, who can become isolated, anxious, lonely and depressed; reasons for this include embarrassment, loss of self-esteem, and reluctance to go out and socialise. Many will not seek help and will sometimes reduce food and fluid intake, along with social contact and activity, to avoid embarrassing ‘accidents’ (Borglin et al 2020; Abrams et al, 2015).

The impact of incontinence on the NHS is also serious. Continence care costs have risen dramatically in recent years. Catheter-associated urinary tract infections (CAUTIs) are estimated to cost the NHS up to £99m a year, while pressure ulcers, often caused by poor continence care, cost the NHS £1.4bn–£2.1bn annually (NHS England, 2018). Francis’ (2013) public inquiry report referred to continence as ‘this most basic of needs’ and yet it was the area of care most often singled out for complaint. The main aims of our study – namely, Percival et al (2021), which was recently published online – were to:

- Hear health practitioners’ views on what helps or hinders good continence care in hospitals;
- Register practitioners’ ideas for improvements in continence care.

Interviews We carried out individual, face-to-face interviews with 27 hospital-based nursing,
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medical and allied health professional staff. Participants were of different grades and had varying levels of experience. All practitioners participating in the study had responsibility for patients aged ≥65 years. Practitioners were recruited in acute inpatient wards (mostly, although not exclusively, care of older people wards) at three hospitals: two large, city teaching hospitals (one, a tertiary referral centre for urology services), and a smaller, non-teaching hospital.

Interviews took place in hospital and were carried out by the lead researcher (John Percival), during which he explored practitioners’ opinions on the:

● Quality of continence care in their setting;
● Ways in which they thought such care could be improved.

Interviews were audio-recorded, then written up, after which the researchers closely read and analysed the text of each interview to extract important points and common themes. The findings from the interviews are summarised below.

What is good-quality continence care?
When practitioners spoke of good-quality continence care they often mentioned practice that was:

● Proactive;
● Encouraged patient independence.

Practitioners saw the importance of proactive care that promotes good-quality, safe, person-centred care, which included early use of the trial without catheter (TWOC) procedure, scheduled toileting and prompted voiding. As one nursing assistant stated:

“[With] patients [with dementia] you need to be a lot more proactive... encouraging them to use the bathroom at those key times when they get out of bed first thing in the morning, before they go to bed, before lunches, before dinners.”

Planning ahead was also important to a physiotherapist; she said that, in the course of her work with patients who had a catheter and restricted mobility, she aimed for a TWOC to be undertaken “early”, as this could help motivate them to increase mobility, and reduce the risk of patients returning home still catheterised.

Encouraging patient independence was said to be a key goal. Practitioners said they wanted to help older patients with incontinence “get back” to their original baseline and be “as independent as possible”. An important part of this was enabling patients who were less mobile to transfer more easily to the toilet; this, practitioners said, helped patients feel stronger, both physically and mentally.

Increased use of the commode or toilet, in turn, reduced the need for pads and catheters, which also promoted independence and wellbeing (Taylor and Cahill, 2018).

Barriers to good continence care
Obstacles to good-quality continence care included:

● Insufficient patient monitoring;
● Overuse of incontinence products, such as pads and catheters;
● Time and support constraints.

Monitoring and record keeping of patients’ continence status, urine levels or bowel movements was not always carried out routinely or kept up to date. Practitioners said this could occur because incontinence was simply not seen as an important issue or could be overlooked:

“Continence care is an important area and the only thing I find is, because it’s such basic care, it gets overlooked and forgotten about at times... some [staff] think there is nothing to worry about. But I think they should do.” (Staff nurse)

Perhaps more regular assessment would have prompted better monitoring, but hospital practitioners we interviewed said assessments were not always thorough enough – a problem that has been identified in previous studies, such as those by Borglin et al (2020) and Holroyd (2015).

Overuse of incontinence products, such as pads and catheters, was repeatedly referred to in interviews. The frequent use of pads, without consideration of the possible health implications, led one nursing assistant to worry that this could:

“encourage incontinence and become an obstacle to keeping people continent”.

A ward sister echoed this point when she drew the conclusion:

“We cause incontinence a bit.”

A physiotherapist added that nurses were:

“always up against the clock [so] it’s easier just to stick a pad on someone [and] not allow them to walk to the toilet”.

A junior doctor noted that an over-reliance on catheters and a delay in their removal:

“can be a very common situation”.

Routine overuse of pads and catheters, by staff who have little time to help patients mobilise, because of understaffing, discourages independence (Taylor and Cahill, 2018).

The overuse of catheters is also linked to urinary tract infections, a problem being addressed by NHS England’s HOUDINI protocol (Public Health England and NHS Improvement, 2017). This protocol, initiated by nurses, is a tool to help with decision making about catheter removal by promoting greater awareness of the indications or criteria for keeping a urinary catheter in place.

There are great examples of initiatives to tackle fundamental aspects of care, such as the Stop the Pressure campaign, which led to a 50% reduction in pressure ulcers (May, 2014). We believe a similar campaign, aimed at reducing the reliance on incontinence products, such as pads and catheters, would offer both health and cost-saving benefits.

Improving continence care
Practitioners’ ideas on improvements to continence care practice are shown in Fig 1.
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**Opening up communication**

Practitioners suggested that talking in a matter-of-fact way about incontinence with patients and inviting feedback would help overcome patients’ embarrassment and build a shared approach to care planning:

“We only uncover things when we ask about them [and] we are less good asking about bowel problems than we are about bladder problems.”

(Consultant geriatrician)

“I do think it’s important we ask questions about how people are managing or not managing.”

(Occupational therapist)

Practitioners knew that only when older patients feel less embarrassed will they openly discuss their continence difficulties and wishes, and find sufficient confidence to participate actively in mobilising, toileting and other aspects of the care process known to promote continence.

The importance of conversations on sensitive subjects has been discussed in other relevant studies, such as Redwood et al (2020) and Wagg et al (2008).

**Care planning**

Interviewees noted that person-centred care plans could be improved by regular, accurate record keeping and by giving continence care a higher profile in intentional rounding. Better care planning would also prompt practitioners to encourage patients’ toilet use and maximise independence. This sharper focus on continence care would help with planning and preventative work, with one positive result being that:

“...we can then avoid the need for catheters” (Senior staff nurse).

Participants also wished to see more forward planning in terms of patient discharge and community liaison. Emphasis was put on improving referral procedures for district nursing and catheter care to lessen delays that occur when discharge letters to GPs were not promptly acted on, and to enable a better “flow” (Junior sister) of information to district nurses.

**Aiding independence**

Participants commonly reported that a primary objective in caregiving was the ambition to help patients with incontinence “get back” to their original “baseline”, or be “as independent as possible”. Enabling patients to transfer more readily to the toilet appealed to notions of normality and was motivational, physically strengthening and had a positive impact on patients’ mental health. In addition, such practice was said to be time efficient:

“If their continence improves by emptying their bladder and bowel [on the toilet rather than the commode] and they feel a lot better because they have sat up [in privacy] in a good position, then they are going to have less interventions for their incontinence.” (C25, Physiotherapist)

**Continence education**

Many practitioners also wanted to see more regular continence care training. Eighty percent of participants told us they had received no “specific”, “formal” training in continence care but had learned “on the job”, by “talking to colleagues” or by “just doing it”. Doctors also conceded:

“We get very little [continence care] training... it’s not high enough on our curriculum.”

“If we did have [continence care] training, we might be able to stop these situations when we have forgotten to TWOC the patient.”

Practitioners also said that continence training would help them consider alternatives to routine pad and catheter use, and better manage patients’ care. It would also help inform hospital practitioners about what might help patients before discharge, so they could signpost them to appropriate community-based treatments, such as bladder retraining and pelvic floor muscle training.

Most practitioners said having specialist continence care leads in their workplace, to give support and advice, would provide opportunities for additional learning on the job, helping them to deliver better-quality care. Other studies have argued that continence training and specialist continence nurse leads should be widely available to health practitioners [Unplanned Admissions Consensus Committee, 2020; Marie Curie et al, 2018; Orrell et al, 2013].

**Conclusion**

Findings from our study help explain the reasons why continence care is not always consistent or of good quality. The study also highlights key opportunities for improving continence care in the hospital setting. Improvements that could save valuable staff time, if put into practice, include more open and effective staff–patient communication, along with more robust care planning, underpinned by regular continence care training, which must be authorised as essential if it is to compete with other claims on staff time. Such improvements would help bring continence care in line with other essential areas of patient care and deliver concrete benefits to individuals and the NHS.

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**References**

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