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

Workshop Chair: Joan Ostaszkiewicz, Australia
03 September 2019 10:00 - 11:00

Start	End	Topic	Speakers
10:00	10:10	Understanding faecal incontinence in nursing homes: What is the problem?	Susan Saga
10:10	10:20	Management of faecal incontinence in complex patients in nursing homes.	Lene E Blekken
10:20	10:30	Quality improvements in nursing homes	Sigrid Nakrem
10:30	10:40	Reframing continence care in nursing homes to accommodate context	Joan Ostaszkiewicz
10:40	10:50	Discussion	Joan Ostaszkiewicz Susan Saga Lene E Blekken Sigrid Nakrem
10:50	11:00	Questions	All

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

Blekken LE, Vinsnes AG, Gjeilo KH and Bliss D (2018). Management of Fecal Incontinence in Older Adults in Long-Term Care. In: Bliss D (ed.) Management of Fecal Incontinence for the Advanced Practice Nurse. Springer

Nakrem S, Stensvik GT, Skjong RJ, Ostaszkiewicz J (2019). Staff experiences with implementing a case conferencing care model in nursing homes: a focus group study. BMC Health Services Research 19:191 https://doi.org/10.1186/s12913-019-4034-0

Ostaszkiewicz, J. (2017). Reframing continence care in care-dependence. Geriatric Nursing. 38(6):520-526. doi.org/10.1016/j.gerinurse.2017.03.014. Available from: http://dx.doi.org/10.1016/j.gerinurse.2017.03.014

Saga, S; Seim, A; Mørkved, S; Norton, C; Vinsnes, AG. (2014). Bowel problem management among nursing home residents: A mixed methods study. BMC Nursing. 13(35). doi: 10.1186/s12912-014-0035-9

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.

1. Musa MK, Saga S, Blekken LE, Harris R, Goodman C, Norton C (2019). The prevalence, incidence, and correlates of fecal incontinence among older people residing in care homes: a systematic review Journal. Accepted for publication in JAMDA
2. Saga S, Vinsnes AG, Mørkved S, Norton C, Seim A (2013). Prevalence and correlates of fecal incontinence among nursing home residents: a population-based cross-sectional study. BMC Geriatrics 13:87
3. Saga S, Vinsnes AG, Mørkved S, Norton C, Seim A (2015): What characteristics predispose to continence among nursing home residents?: a population-based cross-sectional study. Neurourology an urodynamics 34(4): 362-367
4. Saga S, Seim A, Mørkved S, Norton C, Vinsnes AG (2014). Bowel problem management among nursing home residents: a mixed methods study. BMC Nursing 13:35

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 interdepended 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 of 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[2].

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[3].

1. Wagg A, Chen LK, Johnsen T et al (2017). Incontinence in the frail older person. In: Abrams et al (ed.). Incontinence. 6th International Consultation on Incontinence. Tokyo, September 2016.
2. Blekken LE, Vinsnes AG, Gjeilo KH, Bliss DZ (2018). Management of Faecal Incontinence in Older Adults in Long-Term Care. In: Bliss DZ (ed.). Management of Faecal Incontinence for the Advanced Practice Nurse. Springer/ICS.
3. Chadborn NF, Goodman C, Zubair et al (2019). Role of comprehensive geriatric assessment in healthcare of older people in UK care homes: a realist review. BMJ Open, 9:e026921.

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[1].

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[2]. 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 experience and skills in project management, and carrying out PDSA-cycles involve planning projects, being able to acquire knowledge about best practice, and knowing how to measure and implement change. These skills need to be in place in the organisation to succeed in improving care for nursing home patients with faecal incontinence.

1. Lipsitz, L. A. (2012). Understanding health care as a complex system. The foundation for unintended consequences. JAMA, 308(3):243-244
2. Kuipers, P., Kendall, E., Ehrlich, C., McIntyre, M., Barber, L., Amsters, D., Kendall, M., Kuipers, K., Muenchberger, H. & Brownie, S. (2011). Complexity and health care: Health practitioner workforce, services, roles, skills and training to respond to patients with complex needs. Brisbane: Clinical Education and Training Queensland.

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[1]. 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[2].

1. Ostaszkiewicz J, Tomlinson E. & Hutchinson A. (2018). 'Dignity': A central construct in nursing home staff understandings of quality continence care. Journal of Clinical Nursing. 27:2425-2437, doi: 10.1111/jocn.14293.
2. Ostaszkiewicz J. (2017). Reframing continence care in care-dependence. Geriatric Nursing. 38(6):520-526. doi.org/10.1016/j.gerinurse.2017.03.014. Available from: http://dx.doi.org/10.1016/j.gerinurse.2017.03.014