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Privacy and Dignity in Continence Care

Reflective Guidelines for Health and Social
Care Settings

16 February 2009

Centre for Health Services Studies

Introduction

These guidelines are based on the findings from the project 'Privacy and Dignity in Continence Care for Older People', funded and supported by the Royal College of Physicians and British Geriatrics Society. The aim of this two year project was to develop a set of guidelines that can help caregivers in a variety of health and social care settings reflect on their practice with respect to maintaining privacy and dignity in continence care. Other dignity guidelines and toolkits have been developed, but not with the focus specifically on continence. The rationale for this is that, however good the care, people with continence problems in an institutional setting have a high chance of suffering loss of dignity because they need help with very intimate care, and this can have a long term effect on self-esteem and self-respect.

There were three phases to the project. In the first phase it was important to get a view of what dignity in continence care meant from older continence sufferers. Thirty hospital patients and nursing home residents were interviewed. This revealed a number of important attributes of dignity relating to communication with caregivers and developing relationships, having preferences and being able to choose toileting care, and the despair when dignity is lost or compromised. Following this, the purpose of the second phase was to develop the attributes further by seeing how they related to the practice setting. In this phase, ten older people with continence problems were observed as they received toileting care and in addition, findings were checked with older people through interviews. Field notes were also recorded, and data from this phase were used to develop some interesting case studies which are included in this publication. From these two phases some key dignity domains emerged which formed the basis of the reflective guidelines. Further work with practitioners and experts in the field was needed however to help streamline the findings and ensure application to practice. In the final phase two workshops were held with experts from health and social care. The guidelines have subsequently been through wider consultation with stakeholders and will continue to evolve to ensure their relevance to many different care settings. (Go to www.kent.ac.uk/chss for more information on the two year project).

These guidelines highlight the importance of five key domains from the research in relation to continence and toileting and form the basis of the reflections. These are ***dignity, communication and relationships, choice, privacy*** and ***hygiene***.

Who should use this guide?

This guide is intended for all those who provide continence or toileting care in both health and social care settings. It can be used by care managers, nurses, doctors, care assistants, social workers, occupational therapists, physiotherapists, those in educational settings and many others who wish to improve their skills.

How to use this guide:

The guide should be facilitated by one person to a small group of about five to ten people. Groups should be large enough to have a good discussion, but small enough so each person has a chance to speak and contribute.

The facilitator should be a professional who normally facilitates learning in either a health or social care setting. This could be a: care manager, social worker, nursing home manager, ward manager, continence nurse, dignity champion, occupational therapist or lecturer/trainer.

Participants should be those who provide hands-on continence or toileting care, such as care assistants, nurses, or support workers. It may also be useful for all those who communicate routinely with people about their continence, such as doctors.

The pack is divided into five domain sections:

- ❖ Dignity
- ❖ Communication and Relationships
- ❖ Choice
- ❖ Privacy
- ❖ Hygiene

Each of the sections has its own learning aim and can be used on its own or as a whole pack. For example, you can work through the whole pack in a one-day workshop, or you could do one section at a time over a series of days or weeks. You should allow at least one hour to work through each section.

Each domain is broken down into further subsections. Each subsection contains a narrative explaining the main points followed by **quotes**, from the original research project, **questions for group or individual reflection** which relate to the text, references to **policy documents or other significant publications** such as other training materials and research, and **points for practice**, which are suggestions for how to improve practice.

| |
|---|
| Quotes |
| Reflective Questions |
| Policy or other significant publications |
| Point for Practice |
| Case study |

The domains also have a description from a **case study** taken from the observation phase of the project which incorporates many of the themes discussed and will help summarise learning for that domain. Each section ends with an **Action Plan for Practice** section. This is your opportunity to reflect on what was learned and create an action plan on how you might incorporate this knowledge into your daily practice.

In the facilitator's pack there are additional comments in the margin to help you facilitate learning and discussion. They are not prescriptive, but suggestions for how you may want to run your session.

Learning outcomes

By the end of a facilitated discussion you should have a clearer understanding of how the care you provide affects the dignity of people with continence problems. You should be able to think critically about your actions and identify good and bad practice habits. You should have a plan for how you will promote dignity through the delivery of your care.

Additional sources of information

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- Wagg A. (2008) *Nursing Standard: Urinary continence management in older people*. RCN Publishing.

Bladder and Bowel Foundation (formerly Incontact and the Continence Foundation)
www.bladderandbowelfoundation.org

Continence UK
www.continence-uk.com

Help the Aged
www.helptheaged.org.uk

DIGNITY

Promoting dignity in care has become an important target of health and social care services, but this is not always easy to do. Dignity is not something that can be measured because it is based on peoples' feelings, emotions and perceptions and other people's reactions to them.

Learning aims: In this section, you will get a better understanding of how people define dignity and how incontinence threatens dignity. You will be asked to reflect on your own understanding of dignity, and what you can do to help people maintain their dignity when receiving toileting care.

Defining dignity

Dignity is a complex concept, defining it is difficult and it has different meanings for different people, though most agree that it is very important to them.

Dignity means a lot. To keep your dignity, that's what I've always thought, you know. If I can keep my dignity for as long as possible. Dignity means a lot to me.....Well, self-confidence Pride in yourself and sort of, you know.

~Female hospital patient, age 79

Dignity is made up of two parts: a personal part of how we see ourselves, and a second part of how others see and relate to us To maintain dignity it is important that we have both self-respect and respect from others. Being in care however means that too frequently there are times when the balance can be upset and when dignity can be easily lost.

I think dignity is a matter for your own personal judgement and its 50/50 basis with you and the nurses. You do things which compromise your own dignity quite a lot, for example, some patients in wheelchairs don't wear any underwear. I'm talking about men and women. ... it is a question of them bringing in their own underwear and putting it on and insisting and if they do that the nurses will agree and say 'Of course you can wear them,' but if you go to x-ray, the gym or some of these community areas you will see people with no underwear in wheelchairs exposing themselves. It may be that they don't care or they're not aware of it.

~Male hospital patient, age 74

Reflective Questions

1. What does dignity mean to you?
2. Can you think of a time when your dignity was affected? How did it make you feel?

Social Care Institute for Excellence definition of dignity from *Dignity in Care: Adults' services practice guide 09 (2006) pg. 56*

"A state, quality or manner worthy of esteem or respect; and (by extension) self-respect. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self respect regardless of any difference. Or – as one service user put it more briefly: '*Being treated like I was somebody*'."

The RCN's definition of dignity (2008)

Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals.

In care situations, dignity may be promoted or diminished by: the physical environment; organisational culture; by the attitudes and behaviour of the nursing team and others and by the way in which care activities are carried out.

When dignity is present people feel in control, valued, confident, comfortable and able to make decisions for themselves. When dignity is absent people feel devalued, lacking control and comfort. They may lack confidence and be unable to make decisions for themselves. They may feel humiliated, embarrassed or ashamed.

Dignity applies equally to those who have capacity and to those who lack it. Everyone has equal worth as human beings and must be treated as if they are able to feel, think and behave in relation to their own worth or value.

The nursing team should, therefore, treat all people in all settings and of any health status with dignity, and dignified care should continue after death.

For a discussion of definitions of dignity see: *The Challenge of Dignity in Care: Upholding the rights of the individual*. A report for Help the Aged by Ros Levinson (2007)

► Points for practice

Think about your own understanding of dignity. How do you convert this into caring practice with someone who has continence problems?

Loss of dignity

Incontinence is a stigmatising condition which results in loss of control and can cause people to become isolated. As most people do not want to admit that they suffer from continence problems, they often hide it and are less likely seek support from professionals and friends. The loss of dignity people with continence problems feel can be devastating and many feel it reduces their self-worth as a competent adult.

It's these rotten pads that I don't like. It's like you've got a bundle underneath your bottom. That's what loses your dignity when you have to wear those things. They have got small ones but they are no good, they don't soak up the water. You feel such a dope when you wet yourself; it comes through, oh, horrible.

~Female nursing home resident, age 83

Receiving care for continence problems can be uncomfortable for people as the procedures for care are often embarrassing. Feeling uncomfortable with the age or gender of the caregiver can also increase feelings of embarrassment and regret.

While they're wiping me down I do feel embarrassed because some of these nurses are only 20 or 30, you know, and I get very embarrassed and sometimes I break down and they say, 'What are you crying for?' and I say, 'Well, you don't realise, you don't realise, what you're doing.' You see, I feel remorse about this.

~Male nursing home resident, age 88

Reflective Questions

1. Thinking about a person with continence problems that you have cared for, can you remember an incident when they may have suffered a loss of dignity? What did you do to help them regain their sense of dignity?
2. Think about a time when you felt a loss of dignity. Did someone else cause this loss or was it a result of your own actions? How did it make you feel and how did you deal with it?

► Points for practice

People often experience a loss of dignity simply by admitting they have a continence problem and therefore they try to conceal their problem. Consider how you might approach someone you suspect to be incontinent so that they do not feel a threat to their dignity. Choose your words carefully: rather than mentioning the word 'incontinence', perhaps ask if they have trouble getting to the toilet in time. You might then emphasise the medical nature of the condition and potential solutions (such as bladder retraining), or suggest ways to help them manage the problem.

Coping with continence problems

People develop strategies to cope with their continence problems, such as denying there is a problem, hiding it, or planning regular trips to the toilet. Coping strategies can be seen as positive when people make a conscious effort to control and manage their situation, such as by choosing incontinence pads to suit them or controlling their fluid intake. However, people can feel unable to express their choices and preferences when they are being cared for by others, and coping strategies become more like a passive acceptance of their situation, which affects their self-esteem.

Being discreet when providing care or discussing incontinence can help to relieve some anxiety as people may not want others, even family members, to know. Helping individuals to manage their problem themselves as much as possible, such as easy access to pads, helps people to maintain their dignity.

It's like outside people coming to visit you and all that, making sure that they don't see anything, smell anything, notice anything, and I suppose we all want to go out of this premises with a bit of pride I suppose. That's how I see it anyway.

~Male nursing home resident, age 73

It is more difficult for people to maintain their coping strategies in care settings because of the nature of the setting. Though many are initially embarrassed by incontinence and toileting care, they often come to accept it as a part of ageing.

I used to be very embarrassed at one time and shy and all, but I sort of got over it.

~Male hospital patient, age 68

Reflective Questions

1. Can you think of a time when you had to develop coping strategies to deal with a difficult situation? Did they work?
2. Thinking about your care setting, what coping strategies do you think the people in your care have to deal with their situation?
3. What do you think the differences are between coping with a situation and passively accepting it?

Continence benchmark from the *Essence of Care* (DH, 2003)

Factor 7 – Patient access to continence supplies

Benchmark of best practice: Patients have access to appropriate 'needs specific' supplies to assist in the management of their incontinence.

Indicators of best practice:

- Health care personnel are proactive in anticipating the needs and preferences of patients and/or carers.
- Sufficient time is given to enable patients to communicate their needs and preferences.
- Explicit or expressed consent is obtained and recorded from patients prior to treatment or care.
- Patients have access to specialist knowledge and skills.

- Technology is available and is used to meet patient needs, for example, electronic prescriptions.
- The use of services is monitored for example, by regular audit.

► Points for practice

Can you think of any ways in which you could help individuals to manage their continence problems and maintain their own coping strategies?

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Dignity in all aspects of care

The care that individuals receive for their continence problems is just part of the overall care which they receive on a daily basis. A person's ability to maintain their dignity relates to all aspects of care and is affected by the culture and ethos of care settings. Seeing a person as an individual with individual needs can help maintain dignity. Sometimes a person's choice for care may conflict with a medical need, in which case caregivers must negotiate an acceptable solution to both the individual and caregiver. If these needs can be anticipated by the caregiver, conflicts can sometimes be avoided.

Dignity is what I would value more than anything. But not necessarily concerning my visits to the lavatory, but the way this place is run by people... it seems strange that they've taken this job and then behave as if they don't want to do it. And everyday I have to ask for fresh water, everyday I have to ask for this, that and the other. It's not automatic; I think it's automatic for the people who are helpless. I don't know, I've seen jugs of water being taken down the other corridor, but I never get mine unless I ask. But tea in the afternoon is impossible to get unless you keep on saying 'Please can I have a cup of tea?' and they look at you as though you're an awful nuisance.

~Female nursing home resident, age 95

Reflective Questions

1. Have you ever felt you were a nuisance to someone? How did it make you feel?
2. Thinking about the quotation above, what do you think you could do to prevent someone from feeling like a nuisance?
3. Do you think dignity is valued in your work place? How do you know it is or isn't?
4. Is it possible to treat someone in a care setting as they would be treated at home in the community? Or must people adjust to the routine of the care setting?

► Points for practice

How can you ensure that someone with continence problems has dignity in all aspects of their care?

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Scenario – Mary

As we have seen dignity is very important to people with continence problems, but maintaining one's dignity in a care setting can be difficult. Therefore we use different ways or strategies to protect our dignity since losing it can be very upsetting.

Please read the following observed episode of care and then consider the questions below.

Meeting Mary

Mary Ellis is a 75 year old woman of African descent. At the time of the study she had been in hospital for about 5 weeks following a below knee amputation. Mary also had diabetes and her sight was not good. She was undergoing rehabilitation to try and get back home. Mary was completely orientated in time and place. She was very independent, but being a new amputee and wheelchair dependent, she needed help with transferring and toileting. She was not incontinent, but had reduced mobility, which at night resulted in 'accidents'.

The episode

It was after dinner, Mary was desperate to go to the toilet and unable to get a nurse. The toilet in the dayroom was out of action as they were fitting a new sink. The ward was short staffed as one of the nurses was off sick and the nurses who were there had to move furniture around. Mary was sitting in the wheelchair in her own clothes. Mary wished to use a toilet but was told by a caregiver that she would have to use the commode by the bed. The caregiver had this conversation with her across the dayroom and could be heard by everyone in there. Care was efficient rather than gentle. The caregiver spoke to me over Mary, saying that Mary was naughty as she would not use the banana board to transfer onto the commode. The caregiver brought the commode to the bedside, closed the curtains and told Mary to manoeuvre herself onto it. Mary chose to pull her dress right up. Mary wiped her own bottom, but was not offered hand-washing facilities. All equipment was removed and Mary started to propel herself back to the dayroom to get her blanket which goes on her lap and covers her stump. She was eventually brought back by the pharmacist. The curtains were closed around the bed and Mary was allowed to transfer and adjust her own clothing.

Mary's reflections...

I asked Mary what dignity meant to her. She said respect and self-respect. I asked her about dignity in hospital and she said it did not exist; you left your dignity at the door when you came into hospital. She had never bared her body to anyone except her husband, but in hospital the most important thing was to get better. She had got used to men washing her. She said that illness meant that you lost your dignity as a hospital was a public place. She didn't mind because she wanted to get better.

Reflective Question

1. What could have been done differently or better in this scenario?
2. Do you think people should leave their dignity at the door when they enter the care setting?

COMMUNICATION AND RELATIONSHIPS

People in care settings are often frail and vulnerable and effective communication with caregivers is essential in making them feel they are being seen as an individual.

Learning aim: In this section you will reflect on how you communicate with individuals. By the end of this section you should be able to identify why communication is important, and communication styles that maintain as well as take away from a person's dignity.

Building relationships in care settings

Building a relationship with a person is the first step in providing dignified personal care. Individuals value their relationships with caregivers and getting to know the people caring for them gives them security in their everyday routine. Having the same caregivers is important to people, and new 'faces' can make them anxious, especially when receiving intimate care. But this can be reduced if caregivers take a minute to introduce themselves and get to know the person before providing care.

Now the one thing I've found is the more familiar you are with the nurses the better it is and I've been here for 14 weeks and I know every one of them. I know their children; I know their birthdays I have no qualms or loss of dignity when they say 'I'll come and put you in the hoist' and everything. Occasionally a new face appears and I'm a bit apprehensive and some of them are very young....and I do feel a little bit apprehensive about that, but they are only here for a day and they go.

~Male hospital patient, age 74

Building a relationship involves both the caregiver and the individual, but it is usually more comfortable for the person if the caregiver initiates the relationship building with an introduction. Important aspects of building and sustaining a relationship for people in care settings include being greeted with a smile, talked to in a friendly way, being included in carers' everyday lives, and being sociable with time for chit chat, even if this is done while giving care.

'Have you seen what kind of day it is', 'Gosh it's cold outside'. All that kind of thing you know and 'Did you hear from your children', and you know, 'How many children have you got' and you know and all this kind of stuff. Inane stuff that they know is important to the patient, not important to them, but it is important to the patient to keep their minds going with what's going on in their own lives.

~Female hospital patient, age 73

We all have preferences for how we are called, be it formally such as 'Mrs Smith', or informally with a first name. Calling someone by their preferred name shows respect and that you know them as an individual.

Oh yes, they're excellent. They ask you would you rather be called Mrs or by my first name, but to me it's most friendly to say 'Doris', you know than 'Mrs'. I don't mind once being called Mrs, I just say 'Doris', but they speak to you alright.

~Female hospital patient, age 68

Reflective Questions

1. Can you think of a particular person you cared for that you established a good relationship with? How did you do it and what helped?
2. Can you think of someone else you cared where this did not happen? Can you think of why this was and if you could do something differently next time?

Caring for Dignity, Healthcare Commission (2007) pg. 14, Box 1
Common examples of compromises in dignity taken from complaints received by the Healthcare Commission (top 4)

1. Being addressed in an inappropriate manner
2. Being spoken about as if they were not there
3. Not being given proper information
4. Not seeking their consent and/or not considering their wishes

► Points for practice

How well do you know the people you care for? What are three things you would want someone to know about you if they were giving you care? Consider asking a person you care for whether there are three things he or she would like you know to about them.

1.
2.
3.

Caregiver manner and non-verbal communication

It is easy for people with continence problems to feel that they are a nuisance. People value friendly and respectful caregivers who make them feel like an individual. This can be done through your manner – your body language, how you say things and your approach to people. Empathy, or trying to put yourself in someone else’s shoes, can help you communicate more effectively.

It is the kind way you are approached. It is not in a grumpy way or a sort of ‘what do you want now’ way; it is a kindness, ‘What can we do, how can we help you?’.... Well quite honestly this is all just the general approach to you - it is courteous, kind; it is never in any way disrespectful.

~Female hospital patient, age 82

There are some occasions when non-verbal communication is more effective than having a conversation when giving care. The example below shows that sensitive non-verbal communication can be just as powerful as verbal communication.

I wanted to end it all and the funny thing was and I shall never forget this, I just- when they said ‘Are you getting up?’ I just turned my face away, I just hid my face and I never spoke. Nothing at all, and I heard all the breakfast doing and the beds being made and then a nurse came in and said ‘Oh Mrs Jones I’ve come to take you for a shower.’ I thought I don’t want a shower, I want to die. You know I was very down and she took me into the shower room and she washed my hair, washed me very gently, she never spoke and I never spoke and yet she was kindness herself and she dried me gently you know, and she took me back, talced me down, and I don’t know it just... I said to her before I left, I said that I shall never forget that day because I had really reached the bottom, and I said ‘You never spoke to me’, and she said ‘No’.

~Female hospital patient, age 68

However, communication can seem confusing when the verbal and non-verbal signals do not match up, such as if you are saying that you are happy to wait, but then tapping your foot.

Reflective Questions

1. What does empathy mean to you?

2. How do you feel when someone does the following:

- Smiling
- Nodding
- Gentle touch
- Hands on hips
- Sighing
- Rolling eyes
- Shifting weight
- Using gloves when not needed (e.g. brushing hair)

Nursing Standard: Urinary continence management in older people (Wagg, 2008)

Questions for urine storage symptoms

Symptom:

- ▶ Daytime frequency
- ▶ Night-time frequency (nocturia)
- ▶ Urgency
- ▶ Urgency incontinence
- ▶ Stress urinary incontinence
- ▶ Aggravating factors

Question to ask:

- ▶ ‘How many times do you have to pass water in the day?’
- ▶ ‘How many times do you have to pass water at night?’
- ▶ ‘Do you get a desperate need to pass water that you find hard to hold?’
- ▶ ‘Do you wet yourself by accident because you don’t reach the lavatory in time?’
- ▶ ‘Do you wet yourself if you cough, laugh or exert yourself?’
- ▶ ‘Do any of the following aggravate your symptoms: running water, cold weather, putting the key in the door and/or psychological stress?’

▶ Points for practice

1. List some ways that you can be empathetic when caring for someone.

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2. Thinking about your care setting, what are the things that influence the way you talk to people in your care?

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Reassurance and sensitivity

Patients and residents appreciate reassurance and sensitivity during care as they often feel embarrassed about their continence problem and worried that they are causing extra work and being a burden on caregivers.

Well, it's nice to know that people care for a start and the staff have been very kind here you know. Sister the other day....I said I was afraid I'd had an accident in bed you know, she said 'don't worry about it, don't worry about it at all'. I think that's why she came and asked me today because I'm so particular, I didn't want to, you know, cause any problems but no they're always very kind actually and no problem getting up in the night you know, you only have to buzz the buzzer.

~Female hospital patient, age 89

Although patients generally value reassurance, use of phrases like 'not to worry' or 'no problem' may indicate to the person that what has happened *is* a problem or cause for worry. In being empathetic and reassuring, you can recognise and acknowledge that something is a real concern for someone. Maintaining independence can reassure people that they are helping caregivers and this can help improve self-esteem and dignity.

Every morning I have a wash, all my arm etcall round there – I'm encouraged to do that because that saves the nurses a lot of time. The nurses say, 'oh, good old, George, he can wash himself'.

~Male hospital patient, age 74

Reflective Questions

1. Have you ever felt you were a burden to someone? How did this make you feel?
2. What does 'reassurance' mean to you?

Nursing Standard: Urinary continence management in older people (Wagg, 2008) **Impact of incontinence pg. 3**

'Being incontinent is unpleasant, undignified and embarrassing. For many older people it is not something they like to talk about or admit to. You should be sensitive to this even if you, as a care provider, are used to dealing with such problems. Remember, the patient might not, nor never will, become used to it and is likely to be embarrassed. Also remember to use language that the person understands and can relate to. Incontinence can lead to, or be related to, other health problems. It is worthwhile enquiring about these and highlighting any that you identify during an assessment.'

► Points for practice

1. How can you recognise when someone in your care feels they are being a burden?
 2. Think about a person you care for who is anxious about a continence problem. Can you think of some ways to reassure them?
 3. List some reassuring statements that you can use when giving care.
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Explanation and awareness

Explanation, even of routine procedures in continence care, can help people to anticipate what is going to happen and enable them to participate in their care. As the following quotation demonstrates, this individual is appreciative of both explanation and conversation during care.

If it's something I don't know what they're going to do they explain it quite clearly, they always explain what they are going to do...Toileting is very routine, you know exactly what is going to happen. I mean there's still a conversation when you are being hoisted or using the bed pan. It's quite nice.

~Male hospital patient, age 74

Sometimes situations happen where the lines of communication breakdown, such as a procedure not being explained or people misunderstanding something that is being said. When this happens it can make people feel quite miserable and add to feelings of not being seen as an individual. Misinterpreting or misjudging what someone says or how they behave can add to a loss of dignity.

I think on the whole they come through and they say 'Good Morning, how are you?' I say, 'Not so bad, thank you'. 'Are you in a moaning mood?' 'Yes, yes I am.' 'Oh dear.' Because you see it largely depends on what you call moaning. If I breathe deeplyPhew!!... do that, they say that's moaning.... It makes me feel irritable because I know that I am not moaning. I mean my voice changes if I moan. If I started to moan to you, you would know I was moaning.

~Male nursing home resident, age 79

Conditions like deafness or speech problems can be real barriers to good communication and can also affect relationships between caregivers and individuals. Sometimes people struggle to understand caregivers' strong regional accents or where English is a second language. All these factors can confuse people and lead to misunderstanding, and using jargon to explain procedures can also be bewildering and disempowering.

This man is very very good, very thorough, he knows his job, but he doesn't speak any English. When I wanted a toilet roll, he had no idea what I was talking about. I had to get Mei, who's a Sister today and Chinese, to speak to him in Mandarin.

~Female nursing home resident, age 95

I don't understand their jargon, you know. I mean I'm always on pills, but I don't know what, you know, the names they give them and that. But you know, I might say...I'm always asking, 'What's that? What's that for?' and they tell me, but in their own jargon, you know.

~Female hospital patient, age 75

Reflective Questions

1. Think of a time when you couldn't understand what was being said to you. How did it make you feel? What did you do?

► Points for practice

Think of some technical terms that you use regularly that might be confusing to people. Can you think of other words that you can use instead which might be less confusing to people?

Jargon

Plain English

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Time to talk

For people with continence problems, awareness of the pressures on staff and the appearance of busyness can make them reluctant to ask for help. As a result, they can end up feeling quite lonely.

They're very busy. They haven't got time to stop and chat to me. You've got wait until you have a session and you get talking to the person who is teaching you. And there's nobody here apart from you now.

~Male hospital patient, age 72

We're only talking about getting dressed and that sort of thing and as soon as I'm sitting here and he puts this [points to footstool] so that I can put my feet up and puts this [mimics the carer moving a table with her belongings on it next to her chair so she can reach] then he goes. No talking....Well he's busy, he's doing something else.

~Female nursing home resident, age 95

Making time to talk is part of relationship building and although caregivers may find it difficult to find extra time to spend with people they can make sure that the time actually is meaningful and of good quality.

Including individuals in conversations when giving care helps them to feel like an equal in the relationship. When caregivers are talking only among themselves, the person can feel 'talked over', excluded and ignored. By bringing the outside world into the conversations, such as talking about a film or something which is in the news, caregivers can help people to feel connected to life outside of the care setting.

There is one criticism that is constantly being made by the other patients and this is the constant chatter that goes on amongst the nurses when they are serving the meals out. Put them all together in the corridor out there and it's like a parrot house out there. They're talking about holidays, children and everything under the sun. People say if they did a bit less talking we'd all be a lot better... They're entitled to talk but, oh, that racket.

~Male hospital patient, age 74

Reflective Question

1. Have you ever been in a situation where you have been ignored or talked over, such as in a meeting or when with a group of people? How did this make you feel?

Communication benchmark from the *Essence of Care* (DH, 2003)

Factor 9 – Empowerment to communicate needs

Benchmark of best practice: All patients and/or carers are enabled to communicate their individual needs and preferences at all times.

Relevant Indicators of best practice:

- ▶ Health care personnel are proactive in anticipating the needs and preferences of patients and/or carers.
- ▶ Sufficient time is given to enable patients and/or carers to communicate their needs and preferences.

(Refer to www.dh.gov.uk for full list of indicators)

► Points for practice

Think of some barriers you face in finding time to talk to the people you care for. How can you overcome them?

Barrier

Solution

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Scenario - Peter

In this section we discussed different types of communication, both verbal and nonverbal and the types of communication that reassure people with incontinence.

Please read the following observed episode of care and then consider the questions below.

Meeting Peter

Peter, a patient in hospital, was a very cheerful, chatty and educated man. He suffered from a neurological condition which meant he could not walk and had lost the use of his hands and arms so could not hold a urine bottle. He needed to transfer with the aid of two people and the use of a standing hoist.

The episode

This was initiated by the night staff before they settled Peter for the night. He was lying in bed in a hospital gown, chatting to others. He was wearing a pad which was visible and there was an unpleasant smell. He did not appear to be wet but the smell seemed to be one of stale sweat. There was one female caregiver who had a friendly approach. She gave minimal information about what she was going to do but was discreet and gentle. She put the bed at the right position and height for him. Peter used a bottle in the bed which the caregiver left in place and came back for. No attempt was made to cover him up when the bottle was in place. He wasn't washed or wiped and he could not do this for himself. His pad had been dirty and he smelt sweaty. The pad was changed the area was left tidy and he was made comfortable. The care assistant took great care to do up the back of his gown as his shoulders get cold. She also pulled his covers right up the way he likes them. She appeared to know his individual needs well. She said to him, 'you wet the bed last night'. Peter replied, 'It's not something I do of my own volition, in fact it depresses me'. She said, 'I hope you won't do it tonight'.

General reflections about Peter...

Peter was a very chatty man who was always telling stories and joking, particularly when he was in embarrassing situations. In some observed episodes the nurses didn't seem to respond to him. I didn't know if this was because they did not really understand his sense of humour. In a couple of observed episodes Peter was upset about wetting the bed and urinating on the floor. I felt that it was not very sensitively handled, despite one nurses attempts at reassurance. There was evidence of good personalised care but this was sometimes spoilt by rather formal communication.

Reflective Questions

1. Thinking about communication and relationships, what are the positive aspects of this episode?
2. What are the negative aspects of this episode? How could these have been handled differently?

CHOICE

Having a choice in toileting care can help to maintain a person's dignity. Choices help people to feel more in control of their care and are important for keeping their independence. Choices are often restricted in care settings because of the practicalities of providing care. Though people usually have a preference, they are not always given a choice and they do not always feel able to express it.

Learning aims: In this section you will reflect on what choice means in a care setting and be asked to consider how you might give the people you care for more choices.

Time – waiting for attention

A major complaint of people in care settings is having to wait long periods to be toileted after asking for help or being left too long on the toilet or bed pan. People understand that responding to toileting needs depends on busyness and the needs of others who may be more poorly. However, having to wait can lead to accidents that have an effect on a person's dignity.

It's not very quick action. Not the girls fault, they are busy doing something else and they can't get there quick enough and often you have accidents. It is not very nice and you have to scream and shout and tell them you are doing it in your drawers and your running out of time and as I say it isn't always their fault.

~Female nursing home resident, age 83

A consequence of having to wait is having to put up with pain and discomfort, which is not always known to caregivers. People experience pain when having to wait to be toileted and when they are left on the toilet or bedpan too long. People sometimes choose to put up with pain instead of asking for help so that they do not appear troublesome or demanding. Choosing to endure pain is not a preference, but people fear that calling for help will make them a nuisance.

Before lunch or afterwards, [they] put you on the commode and then they go off to someone else and leave you on it and it nearly kills you...Very impersonal and catches your bottom and everything, it is really horrible. If they would take you off the commode directly you have done it and put you in your chair I would be a lot happier but they don't, they get off and do something else, always in the evening.

~Female nursing home resident, age 83

While some people may feel that too much time is taken during toileting, others feel that some episodes of care can be too rushed. People appreciate care that is not only efficient and thorough, but also includes time to chat with the staff caring for them.

We have one girl, and she's 'crash, bang, wallop' – 55 to 60 seconds and we've one or two others that prolong it, say quarter of an hour... Well I think the quarter of an hour one is the best because everything is done in detail rather than the crash, bang wallop, you know.

~Male nursing home resident, age 73

Reflective Questions

1. How would you like to be cared for if you were in care and needed help to use the toilet?
2. What can you do to make sure that people aren't kept waiting or stop people from feeling rushed?

► Points for practice

Think of some barriers you face that cause you to keep people waiting or force them to rush. How can you overcome them?

| Barrier | <u>Waiting</u> | Solution |
|---------|----------------|----------|
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| | | |
| | | |

| Barrier | <u>Rushing</u> | Solution |
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Gender of Caregiver

People often have a preference for the gender of the caregiver giving them personal care, often for a caregiver of the same sex. However, people realise they do not always have a choice in the gender of caregiver because of staffing arrangements and therefore they often adjust to care from the opposite sex. How care is given is the most important factor.

I must say at 82 going on 83 I prefer to be with ladies; I know that it is sometimes impossible, but that is something I would prefer.

~Female hospital patient, age 82

This morning I was very disappointed because usually I have the sister Mei and instead I had the man who speaks French. And he dashed in and he said 'Wakey wakey!', I said 'Are you going to get me up?', he said 'Yes'. I said 'Isn't Mei here?', I didn't hear what he said so I thought she wasn't here. Later I saw her and I said 'Why didn't you look after me as usual?' and I didn't understand what she said... Anyway, Jacques did very well, but that was something unusual for me to be got up in the morning by a man, you know.

~Female nursing home resident, age 95

However, people also want discreet and gentle care and when care is delivered in this way it can compensate for not having a caregiver of the same sex.

Reflective Questions

1. Would you prefer to be cared for by a woman or a man? Why?
2. The Department of Health (2007) announced that mixed-sex accommodation in the NHS should be eliminated where possible to ensure dignified care. However, in the same report there is no mention of mixed-sex caring and how this impacts on someone's dignity. How do you think the older people that you care for feel about being cared for by someone of the opposite sex?

► Points for practice

Ask the people you care for if they have a gender preference for the person who cares for them. Also ask if they have a preferred person to carry out the care.

Routine and exercising choice

As with gender, people in care generally have a preference for the type of toileting facility they use. A bedpan is usually seen as the quick option over a commode or toilet, where the care can take up more time and staff, or be dependent on equipment like a hoist. Most people prefer not to use a bedpan where possible, but sometimes they do not have a choice. This may be because of staff shortages or because staff are busy and they don't want to add to this. Most people become accustomed to the routine of the care setting. This is not to say their preferences have changed, but that they may not feel supported by staff or confident enough to express their preference, or understand that there is a choice.

Participant: No. There wouldn't be a choice. The reason is that the hoist is in constant use with other patients and trying to get hold of it is very difficult and I think if you wanted the bed pan, invariably that means that you need to go so they're quite quick with it and they don't hang about.

Interviewer: OK. If there were more hoists would it happen do you think?

Participant: I think they would say, 'What do you want a hoist for? Why not use a bed pan?', and I think I would be unable to find a reason why I had to have the hoist, but I don't think having more hoists would make any difference.

~Male hospital patient, age 74

Exercising choice may be seen as imposing or interrupting the routine of the setting which may create more work for staff. People fear they might be viewed as a nuisance, both by staff as well as by others in the care setting. Choices can be limited because views of what is acceptable behaviour change when in care. For example, people see and hear others asking for things and this is seen as demanding, so there is a tendency to change their behaviour in order to be seen favourably by caregivers.

Well until about two weeks ago I used to have to wait for them to come and help me with my pad, and I got fed up with sitting on the toilet and being a nuisance quite frankly. It was very often made quite clear that I was asking for help too often. 'It's only half an hour ago', but that's it.

~Female nursing home resident, age 95

Since the consequences of exercising choice (such as being seen as troublesome by caregivers and others) appear worse than not exercising choice, people often choose a route that is easiest for staff. Although not ideal, individuals develop their own ways of managing the situation. In the following example the patient is using an opportunity to mutual advantage by getting the nurses to put him on the hoist and to lower him onto the bedpan in the wheelchair.

It's strange because when I get out I always take the opportunity of having the bedpan because it is a good opportunity. It saves the nurses work, it's good for me because I'm in the hoist, it's more comfortable for me and it saves the nurses having to roll me over and push bedpans underneath me. So its better all round.

~Male hospital patient, age 74

Caring for Dignity (Healthcare Commission, 2007)

'The wishes of older people are often disregarded in the delivery of care, despite having expressed their wishes at the time of admission. This leads to an unresponsive care package. Care planning is therefore the first step to ensuring that care is centred around the individual.'

Reflective Questions

1. Think about a time when you were not able to have a choice. How did it make you feel?
2. In the first quote the person feels he has to justify his choice of using the commode instead of the bedpan. What do you think of this?
3. Do you think there are times when it is OK to restrict people's choices? Why or why not?

► Points for practice

1. Do you think there are times when it is alright to restrict people' choices? When would this be? How do you explain to the person in your care?
 2. Thinking about the last quote, how much do you think that people should adapt to their situation?
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Scenario - Brenda

As we have seen, people have preferences but their 'real' choices are often restricted because of caring needs or the limitations of the setting itself. Certain elements of care do not always allow for choices to be fulfilled. When individual's choices are overruled by caregivers, the reason is not always explained to the person which can cause them further distress.

Please read the following observed episode of care and then consider the questions below.

Meeting Brenda

Brenda Parker is a 75 year old woman of white ethnic origin resident in a nursing home for just over 2 years. Brenda is unable to walk and has very limited movement in one of her hands. She has reflex and stress incontinence and can have loose bowels. She has an urgent need to pass water and does wet herself and lose control of her bowels. She feels her incontinence problem affects her social life, when family and friends visit and when she goes for trips out.

She said she was very anxious about needing the toilet when going out, worrying she smells (e.g. when she has visitors or people walk past her room), and she feels embarrassed. She always uses a commode during the day and a bed pan when in bed at night.

The episode

Brenda had just finished going to the toilet. The staff were jolly and friendly, and Brenda's dress was covering her so she wasn't unnecessarily exposed, but when the staff wiped her this appeared minimal and rushed. However when Brenda appeared anxious about the lack of wiping the staff reassured her that it wasn't necessary as she hadn't done very much. 'It was only a malteser' the caregiver replied. When being hoisted off the commode Brenda seemed conscious of people walking past her window (people had to walk past her window to get to the main entrance of the nursing home), her main light was on and curtains were open. The staff reassured her that they could not see in. Once gently back in her chair Brenda asked if she could have her fragrant spray, again the caregiver assured her that she didn't need it as there was no smell, especially as she had only passed a small amount.

Brenda's reflections...

Brenda said the main problem she has is 'When you want to go you have got to go', so she said you can buzz but unless the staff come almost straight away she wets herself. She said they reassure her that it is okay as she is wearing a pad, but she gets embarrassed and worries she smells. She doesn't want to be 'a smelly old lady'. When she is toileted she thinks they are very good, gentle and discreet, but she said she is not wiped as well or as thoroughly so she would like. She said she would like wet wipes when toileted and changed at other times though, to relieve the anxiety that she smells. As experienced in an earlier event she likes to use the fragrant spray sometimes to help with this, particularly if opening her bowels, but she has to ask when she wants to use it. She also would like to use a proper toilet rather than a commode if she could.

PRIVACY

Maintaining people's privacy is fundamental to maintaining dignity, and this is particularly so for people with continence problems.

Learning aim: In this section you will reflect on the importance of privacy in care settings and understand which situations compromise a person's privacy as well as ways to ensure someone's privacy.

Privacy and dignity

Privacy and dignity are often linked together in documents, but unlike dignity, privacy is far easier to understand. While dignity is more abstract, based on emotions and feelings, privacy is physical and can be recognised through sight and sound, such as closing a door and speaking softly. Privacy is easier to maintain in some care settings, such as those with ensuite facilities, than others.

Yes, you can't get no more privacy than this [private, ensuite room]; door locked, no one can walk in and walk out while you're being seen to.

~Male nursing home resident, age 88

Privacy during personal care is important for maintaining dignity, but sometimes too much privacy when it is not needed can lead to feeling isolated and lonely.

What I don't like is having the door shut all the time. You can't have the door open because you are supposed not to, but I do. I have it closed then, I have it about that much closed. I don't mind that. ...I don't mind if somebody is in here, it is nice to have the door closed cos people don't know who's in then. Anyway sometimes you have to have it closed because you are stark naked and what not.

~Female nursing home resident, age 83

Privacy is more difficult to maintain in communal care settings such as hospital wards. Caregivers are dependent on the use of curtains around the bed to ensure privacy, but curtains do not always fit well and are not secure or sound proof. The use of red 'no entry' pegs clipped to curtains have been used in some areas to prevent people entering a bay when people are having personal care. Caregivers can also make sure that people have periods during the day, such as meal times, when they are not disturbed by nurses, doctors and other caregivers.

If you need the commode or anything like that then the curtains are always drawn and nobody ... only the nurse could just peep through and say, 'Are you all right Mrs B?' and I'd say, 'Yes'. 'Well if you need any help just ring this.'

~Female hospital patient, age 79

Curtains do not give privacy with respect to sound which is a problem for both maintaining confidentiality and dignity. People sometimes feel that staff speak too loudly behind the curtains and worry that others can hear what care they are receiving, their medical history

or social circumstances. Just as individuals do not want others to hear their confidential information, they do not want to hear what is happening to the other people.

Interviewer: And what about speaking behind the curtains, do you feel that this is private?
Participant: *Not particularly because you can hear what people say. During the night it is very bad because you wake up and you hear one of the nurses saying, 'oh Alfie, my god, what have you done?' So you know somebody has done something in their bed... The curtains are drawn, but you hear every word they say and I don't want to know what he's done but I don't have any choice... There is no voice privacy behind the curtains.*
~Male hospital patient, age 74

Reflective Questions
1. If you were being cared for, what would you want caregivers to do to ensure that your privacy is maintained?

Behind closed doors: using the toilet in private (Available from the British Geriatrics Society www.bgs.org.uk)
Some examples of poor practice which denies dignity

- ▶ Insisting that patients use commodes or bed-pans when they could be taken to the toilet.
- ▶ Entering closed curtains without ascertaining why they are closed.
- ▶ Leaving patients in full view of others when using toilets.
- ▶ Not offering people hand washing facilities after using the toilet.
- ▶ Using safety as a reason to deny choice.

▶ Points for practice
Thinking about your work environment, How do you ensure that the individuals you care for have enough privacy when giving personal care? Can you think of any ways in which you could improve privacy for individuals?
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Accepting help with intimate care

As people living in health and social care settings become more dependent they have to accept help with intimate personal care from others, often people they do not know.

I don't know what my dear husband would think of somebody else doing all that for me but there you are. It's just as well you don't know what's round the corner, isn't it?

~Female nursing home resident, age 77

Some people appear unable to make this adjustment to accepting help and find their own solutions. In the following example, despite having been in hospital for three weeks, this person waits to have his bowels opened until his wife visits as he does not want to be taken to the toilet by care staff.

Participant: *My wife comes in, thank goodness and she takes me every morning for a shower and I can use the toilet while she's here, round about 11.30 -12.00. I do want to go while she's here.*

Interviewer: So do you time it?

Participant: *I try to.*

Interviewer: Will you hold on rather than have somebody else?

Participant: *I've never had to have somebody else... they gave me medicine because I was bound right up, I couldn't go at all. They gave me medicine so I could go through the eye of a needle, I couldn't hold onto it but luckily it happened while she was here. It was really good.*

Interviewer: And has it happened, the odd time, that you've needed to go while she wasn't here?

Participant: *Not so far.*

~Male hospital patient, age 72

Privacy and Dignity benchmark from the *Essence of Care* (DH, 2003)

Factor 3 – Personal boundaries and space

Benchmark of best practice: Patients' personal space is actively promoted by all staff.

- ▶ The name the patient wants to be called is agreed.
- ▶ The acceptability of personal contact (touch) is identified with individual patients.
- ▶ Patients' personal boundaries are identified and communicated to others for example using the patients own language.
- ▶ Personal space is respected and protected for individuals.
- ▶ Strategies are in place to prevent disturbing or interrupting patients, for example knocking before entering.
- ▶ Privacy is effectively maintained, for example, using curtains, screens, walls, rooms, blankets, appropriate clothing and appropriate positioning of patient.
- ▶ Single sex facilities are provided and whether there is access to segregated or age specific toilet and washing facilities.
- ▶ Clinical risk is handled in relation to privacy.
- ▶ Privacy is achieved at times when the presence of others is required.

Reflective Questions

1. If you realised a client in your care was becoming distressed because of 'holding on' until visits, how do you think you could help to resolve this problem but ensure his dignity was not compromised?
 2. How can you help people to feel more comfortable with receiving intimate care?
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Nakedness and exposure in the care setting

Most people like to keep the private parts of their body covered and avoid unnecessary exposure. Having continence problems means that there is a greater likelihood that people may lose their dignity through exposure. Older people are especially private about this because of the way they were brought up and because many feel embarrassed about the way their body looks as it ages. However, when in care settings people become accustomed to being exposed in certain circumstances. Behind the curtains and in the privacy of their own rooms, individuals become used to having personal care delivered while they are exposed.

If they are going to express my nakedness to the world they do it behind the curtains and I am quite pleased about that because although I am in the profession which I am, I am fairly modest about myself and don't like to expose my nakedness too much.

~Male hospital patient, age 90

In some care settings it is quite common for people who are not as mobile to be naked from the waist down and only covered with a sheet when sitting in a chair or wheelchair, though it is not necessarily appropriate. People often come to accept this as normal because it is easier for staff, even though initially they may find it distressing.

Interviewer: How do you feel about not wearing trousers?

Participant: *That's a good question, originally I did when I first came in and I couldn't get the bottle under there. A fly opening isn't wide enough and I couldn't get the bottle in there so they said, 'you're going to have to take your pyjamas or your pants off'. I wasn't too happy about that but I could see why they did it so I did that. That's the reason. I mean if you don't use a bottle, fine, its no problem but I use the bottle in bed and if I struggle with it it wets the bed and I don't want them to keep changing the sheets all night.*

~Male hospital patient, age 74

Reflective Questions

1. How do you feel about your body? Would you be alright with being seen naked by someone who does not know you well?
2. Imagine yourself sitting where you are right now and being naked from the waist down, covered only by a sheet. How would you feel? Is there any setting in which you would feel comfortable like that? Why or why not?

► Points for practice

Do the people you care for sit in bed or in a chair naked from the waist down on most days? Why do they do this – is it for their comfort or to make care easier for caregivers? Ask them how they feel about it and if they would prefer to wear pyjama bottoms or other clothes.

Scenario – Lucy

In this section we have thought about various ways to make sure things are kept private from being seen, but often we overlook that private things can be heard too.

Please read the following observed episode of care and then consider the questions below.

Meeting Lucy

Lucy is 87 years old and had been a resident in a nursing home for one year following a broken hip, a series of falls, and not being able to cope at home. Haemorrhoids and a rectal prolapse had led to incontinence problems. Staff said verbally that she has faecal incontinence, but it did not match written information which said she had occasional bladder accidents. Lucy wears pads all the time and is unable to walk unaided. She has a hearing problem and doesn't always wear her hearing aid. Lucy's overall manner with staff was uncomplaining and compliant.

The episode

This morning's shift was very busy with wheelchairs, hoists, drugs trolley, staff, residents and visitors all crammed into the dayroom. After lunch Lucy was taken to the toilet even though she argued that she didn't want to go and there was no point. There was a loud exchange that was audible in the dayroom between Lucy and the carer who explained 'you are incontinent, that is why we have to take you to the toilet'. The staff were otherwise gentle, their body language was sympathetic and they explained what they were going to do as they took Lucy to the toilet. There was not room to go into the cubicle, but my guess was that the pad was wet and was changed. Afterwards Lucy came out smiling, looked settled and comfortable and thanked the staff several times.

Reflective Question

1. How can you ensure that trips to the toilet are discreet and private from start to finish?

Action Plan for Practice – Privacy

This is your chance to consider how you can change your practice to incorporate some of the points discussed in this section. It is an opportunity to write a 'care plan' for yourself-goals for your practice, things you want to try to do better to improve the lives of the people you care for. You can use the following prompts to help guide your plan.

- ▶ How can I ensure that people's privacy is protected?
- ▶ If I was in care, what would I like a caregiver to do to maintain my privacy?

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HYGIENE

Hygiene is important for preventing infection and ensuring that we feel comfortable about ourselves. Feeling dirty and smelly can negatively impact on dignity, especially for those with continence problems as they may already feel ashamed of their problem.

The importance of being clean

Feeling clean and comfortable is important to people with continence problems. Being clean and having continence products hidden helps people feel confident that their continence problem is not noticeable to others. Having products, like pads, rationed takes away from a person's dignity and makes them feel childlike and like a nuisance.

Oh well, you've lost nearly everything, you know what I mean? You know, you don't like going out far and if somebody comes by and they give a sniffle you think it's you; you know, that sort of thing. You're very conscious of it the whole time. Yes, you certainly are. And you just wonder, do people know? You haven't told them, you know, but you just wonder, do they suss you out, you know? No, I'm very, very conscious of it all the time. Yes, it's worse than having a big lump on your nose or something.

~Male nursing home resident, age 73

Having a clean and hygienic environment is also important. People appreciate having clean bedding everyday. Most people prefer being cleaned as you would at home with a bath or shower. Sometimes this is not always possible, but many times it is not offered. People do not always feel comfortable asking for a bath or shower because it means creating more work for staff. Some people have a relative or friend who can voice their concerns, but others do not.

I just had a strip wash today because I have my bath tomorrow, which is better than just washing isn't it? You know, and that was my daughter that lives here that got on to them about this.

~Female nursing home resident, age 77

Good practice in continence services (DH, 2000), pg. 13

3.12 There is an unacceptable variation amongst NHS Trusts in the type, quality and quantity of continence supplies made available to patients... They are an essential component of the management of incontinence that should normally only be issued after an initial assessment of when a management plan has been completed and reviewed. Offering pads prematurely can lead to psychological dependence upon them, and reluctance to attempt curative treatment. Key principles [for continence supplies] are:

- ▶ pads only issued after an initial assessment;
- ▶ full range of products available;
- ▶ supply of products should only be governed by clinical need;
- ▶ needs are regularly reviewed.

Reflective Question

1. What is your daily routine for washing? How would you feel if you were only able to do this once a week?

The cleaning process

People who need help with toileting and personal care value gentleness, thoughtfulness and touch. Washing, when done tenderly, can be symbolic of a much deeper caring and understanding of the person's emotional needs.

They've washed me and taken care of me and they've done it with gentleness and kindness and chat.

~Female hospital patient, age 73

Too often people feel that washing and wiping is too quick and cursory. While people appreciate efficient cleaning, they also want to be sure that it is thorough.

They are always in a great rush, oh - dreadful. Sally is very good, she is the sister today, she's intelligent and she's quick, but she's too quick... Sometimes she can't wait for me to dry my legs before she starts washing my back, and in my opinion she doesn't do it thoroughly, you know leaves part of my back unwashed, but she swears she's done it.

~Female nursing home resident, age 95

People usually are keen to do as much washing for themselves as they are able, and often described the importance of this as part of their daily routine. Being able to wash oneself is a source of pride for many people as it makes them feel useful and maintains their independence.

This year I was in hospital for 2 weeks and I lost all dignity there. But here it's not so bad because they let me help wash myself as much as I can.

~Female nursing home resident, age 77

Reflective Questions

1. Thinking about your bathing routine, how would you feel about someone else doing it for you?
2. What is your understanding of 'being clean'?

► Points for practice

What do you do to make sure that the people in your care are as clean as they would like to be? Is there ever a difference between your ideas of 'clean' and the person in your care's ideas of 'clean'?

Cleaning up after accidents

People who have continence problems are not able to control their bladder and bowels and it is important to them that staff recognise and acknowledge that accidents are not their fault. When accidents do happen it is important for people that they be cleaned up with a minimum of fuss. Although cleaning up needs to be done quickly, you might need to spend a bit of time with the person to reassure them and maybe talk to them about any possible ways in which the accident could have been avoided.

They know that you can't help it, they know that you're going to wet the bed or worse, they know they've got to come in when the bell goes and clean it off, whatever time day or night. They just do it, bless them, they're very very good, they really are.

~Female hospital patient, age 97

Reflective Questions

1. How would you feel if you accidentally lost control of your bowels in your work place? How would you want the incident dealt with by your colleagues?

► Points for practice

Do people you care for apologise when they've had an accident? Do they seem embarrassed and upset? What do you do to reassure them? What strategies do you put in place to prevent this from happening?

Scenario – Edward

Please read the following observed episode of care and then consider the questions below.

Meeting Edward

Edward is a 79 year old man who had been in hospital for 10 days. He had a catheter for urinary incontinence and had some problems with faecal incontinence following an infection. These problems were highlighted in his care plan. He wore pad and pants day and night. Edward was mentally alert, with a quiet somewhat shy manner. He was usually in bed or sitting beside his bed, and hardly ever ventured into the dayroom.

The episode

Edward seemed to have been on the bedpan for quite a long time. There were 2 staff on and the ward was averagely busy. Edward was in bed wearing a hospital gown. He had an incontinence pad in place and a leg bag for his catheter. There was an unpleasant smell. Having missed the start of the event, I came behind the curtains to see him being taken off the bed pan. A female care assistant was carrying out the care alone. She called Edward by his preferred name but did not seem friendly and instructed him rather than explaining what she wanted him to do. She was gentle but rather brusque in the way she carried out the care. The curtain was drawn around but Edward was left exposed – his pad and pants pulled down and no attempt was made to cover him up. He was given a very cursory wash with a wet wipe and catheter care. He had had his bowels opened. The sheet was still stained with faeces at the end of the event but I do not think the carer saw it. Edward was left looking comfortable with his belongings and the buzzer within reach. The carer carried out the care efficiently but was a bit irritable. She asked Edward what the time was, she asked in an irritated way and had not spoken prior to this, he was slow to answer the question as it took him by surprise – she had to ask him again.

Reflective Question

1. What steps do you take to ensure that the people you care for and their bedding and/or clothes are clean after toileting?

