

# **FINCH** Faecal **IN**continence in people with advanced dementia living in **Care Homes**



**Aim:** To explain the effectiveness of programmes that aim to improve faecal incontinence (FI) in people with advanced dementia in care homes.

# Emerging from the swamp

Both reviewers and commissioners should anticipate that 'focusing the question' will be a time consuming and ongoing task, often continuing to the half way mark and even beyond in a rapid review. We have previously referred to this stage of the synthesis of complex evidence as '**the swamp**', and advised that acknowledging its uncertain and iterative nature is critical to the success of the review process (Realist synthesis: an introduction, Pawson, Greenhalgh, Harvey, Walshe, 2004).



Expect outcomes depend on type of incontinence

The way to attain those outcomes requires assessment of the person decisions about the best interventions FI specific then communication + implementation of those interventions

If Mr X poo is in wrong place, where? why? what do we do? How do we do it?

- urgency (distress)
- overflows (constipation)
- comorbidity (ortho issues)
- functional (access, impairment)
- controllable
  - dementia (psychosis) specific (brain circuit dysfunction)
  - anastomosis (pouch dysfunction)

OUTCOMES  
of level  
essence  
of functional

Continent

Recognise or use toilet

Minimise leakage

Skin integrity

Comfort

Minimise distress

Dignity

## ASSESSMENT

In care homes  
PCC  
protocols  
guidelines  
FI specific  
dementia specific

## INTERVENTIONS

Biomedical  
Social/care  
environmental  
containment  
FI or dementia specific

## PERSON

level/TYPE OF CONTINENCE  
level/type of dementia  
preferences  
level/type of ability

Remember to look at LD literature, implementation in care environments literature

COMMUNICATION

IMPLEMENTATION

PERSON  
OUTCOMES

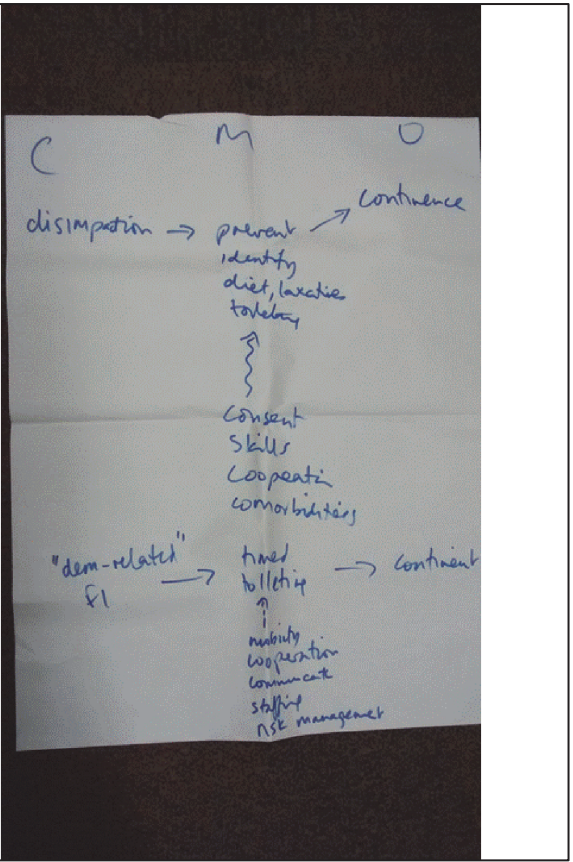
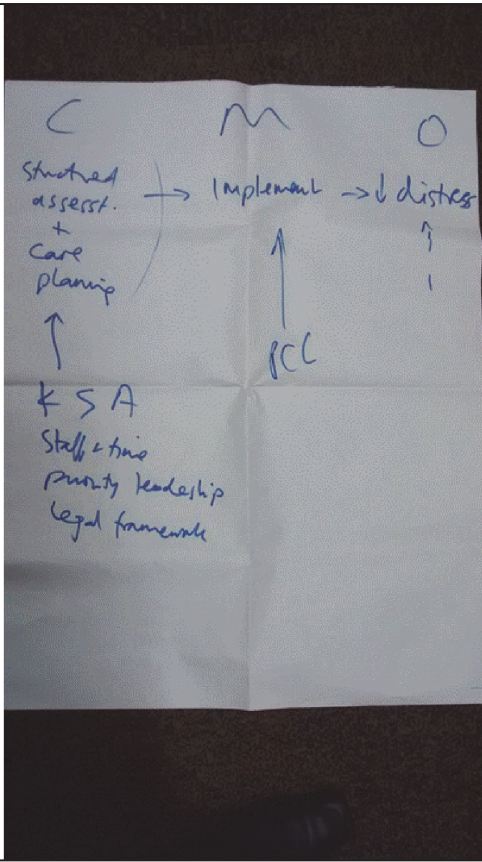
STAFF + ORG 'OUTCOMES' or consequences both affect communication + implementation + person outcomes

Our first go at 'data extraction'...

Study	Author Title Publication date DE date Search source Study Type Study Description Study size: no. participants/care homes etc Care home vs. Resident	
Focus	Dementia Urinary Incontinence Faecal Incontinence Care Home Continence Intervention Implementation Research in Care Home Older people (>65) PCC Other	Theories Protocol driven assessment and care planning Staff skill mix and autonomy Facilitation and access to expert support Communication between patients – carers – clinical staff – non-clinical staff Access to services/specialised staff and resources Person-centred care/empathy Timed-toileting Staff knowledge and training Time to care Containment and pads The type/level of dementia the person has is key The type/level of faecal continence the person has is key
Study	Explicit	
Hypothesis	Implicit quote	
	Is it worth going on...?	
	Quality & comments	Study quality (Think: CASP critical appraisal) Other comments, nuggets
	Outcomes	Resident Staff Organisational Cost/resource FI specific Other Reduction vs. management
		Queries about what was actually done Do any components link to 'If...then' statements? Does this prompt need for any lateral searches? What?

Author	Title
Willems (BR)	Staff-resident interactions in long-term care for people with dementia: the role of meeting psychological needs in achieving residents' wellbeing
Schnelle (BR/MB)	A Controlled Trial of an intervention to improve urinary and fecal incontinence and Constipation
Fossey (BR/MB)	Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: cluster randomised trial
Fossey (BR/MB)	The disconnect between evidence and practice: a systematic review of person-centred interventions and training manuals for care home staff working with people with dementia
Chenoweth (BR)	Caring for Aged Dementia Care Resident Study (CADRES) of person-centred care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial
Roe (BR)	Systematic review of the management of incontinence and promotion of continence in older people in care homes: descriptive studies with urinary incontinence as primary focus
Ahnter (BR)	Faecal incontinence in older patients
Alkpen (MB)	Factors contributing to fecal incontinence in older people and outcome of routine management in home, hospital and nursing home settings
Al-Sammari (BR)	Introducing a New Incontinence Management System for Nursing Home Residents
Bellizzi (BR)	Fecal incontinence—a review
Booth (MB)	A feasibility study of transcutaneous posterior tibial nerve stimulation (TPTNS) for bladder and bowel dysfunction for elderly adults in residential care
Coggrave (BR)	Management of fecal incontinence and constipation in adults with central neurological diseases (Review)
Flanagan (BR)	Factors with the management of incontinence and promotion of continence in older people in care homes
Heckenberg (BR)	Improving and ensuring best practice continence management in residential aged care.
Doutleider (BR)	Effects of prompted voiding on fecal continence among nursing home residents.
Potter (BR)	National audit of continence care for older people: management of fecal incontinence
Termin-Greener (BR)	Nursing/Homework: Environment and the Risk of Pressure Ulcers and Incontinence.
Tobin & Brocklehurst (BR)	Faecal incontinence in residential homes for the elderly: Prevalence, aetiology and management.
Andrews (BR)	Maintaining continence in people with dementia
Arvanitakis (BR)	Nutrition in care homes and home care: Recommendations – a summary based on the report approved by the Council of Europe
Fader (BR/MB)	Absorbent products for urinary/faecal incontinence: a comparative evaluation of key product designs
Jung Schelle (MB)	Urinary and fecal incontinence in nursing home residents
Rahman, Schelle (MB/BR)	Distance coursework and coaching to improve nursing home incontinence care: lessons learned.
Rahman (BR)	Implementing toileting trials in nursing homes: Evaluation of a dissemination strategy
Flanagan (BR)	Systematic review of care intervention studies for the management of incontinence and promotion of continence in older people in care homes with urinary incontinence as the primary focus (1955-2010)
Boord (BR)	How education can improve care for residents with dementia.
Mattis (BR)	Bladder buzz: the effect of a 8-week evidence-based staff education program on knowledge and attitudes regarding urinary incontinence in a nursing home.





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**ELIGIBLE:** NH resident of six nursing v  
with FI NOT comatose or short stay

445 eligible, 153 consented, 125 randomised, 112 completed  
I65 C60 I58 C5

**INTERVENTION** **CONTROL = "usual"**

12 weeks, 5 weekdays each week, 7-339pm  
in each intervention day 4 interventions every 2 hours  
Implemented by trained research staff

**AN INTERVENTION =** check for incontinence  
+ prompt to use toilet (1)  
+  
offered food + fluid (3)  
+  
prompted to exercise  
(sit to stand + walking on wheelchair propulsion) (2)

**MEASUREMENTS** - baseline taken  
Physical activity + food + fluid intake  
- 2 days each month - X6 measurements  
for intervention + control during intervention period

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**BASELINE MEASURES**

3-4 participants / researcher  
125/4 = 26  
125/3 = 41  
26-41 extra staff  
4-7/home  
Extra staff used

**CONTINENCE**

10 days pre-intervention all participants  
4 checks/day  
Initial morning change to ensure dry undergarments  
check clothes for evidence of UI or FI (wet/dirty)  
Research staff changed if needed + provided toileting assistance if requested

Say they use no voids in toilet for denominator but don't say how/when measured. not clear how voids assessed  
Also measuring re bowel movement (from voids + clothes/diaper)

**INTERVENTION GROUP** continence measured during intervention.

**CONTROL GROUP** continence measured for the 10 days after intervention  
Not clear what other care was provided to intervention group between checks.

**MEASUREMENTS** - baseline taken  
Physical activity + food + fluid intake  
- 2 days each month - X6 measurements  
for intervention + control during intervention period

## A Controlled Trial of an Intervention to Improve Urinary and Fecal Incontinence and Constipation

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Linda Beuscher, PhD, GNP,<sup>#</sup> Emmett Keeler, PhD,<sup>§\*\*</sup> Jack W. Clift, MPP,<sup>\*\*</sup> and Sandra Simmons, PhD<sup>\*\*†</sup>



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3-4 <sup>interviewees</sup> participants / researcher

•  $125/4 = 26$  26-41  
 $125/3 = 41$  extra staff  
 +7/7/home  
 Extra Staff used

Physical Activity + Mobility endurance Measures

PRE-INTERVENTION BASELINE  
 all participants wore movement device for 8hrs on 2 separate days  
 distance resident could walk or wheel chair in 10min  
 2 separate trials/assessments separate days  
 Sit stands how many in 30sec, 2 trials separate days  
 STANDARDISED PROTOCOL

Food + Fluid intake

PRE-INTERVENTION BASELINE (ref 20)  
 observation estimation - 2 days - used valid reliable protocol  
 Each participant observed at mealtimes (x3/day) between meals (x3/day)

DURING INTERVENTION/ MEASUREMENTS  
 Physical activity + food + fluid intake - 2 days each month - X6 mealtimes for intervention + control during intervention period

POST-INTERVENTION  
 only physical activity + mobility measured post intervention (2 days)

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3-4 <sup>interviewees</sup> participants / researcher

•  $125/4 = 26$  26-41  
 $125/3 = 41$  extra staff  
 +7/7/home  
 Extra Staff used

RESULTS IN ABSTRACT

INTERVENTION

- ↑ Physical activity
- ↑ frequency of toileting
- ↑ food + fluid intake
- ↑ UI
- ↑ frequency of bowel movements
- frequency of FI and NOT change

Weight was other measure

## DISCUSSION

The results of this randomized controlled trial showed that the multicomponent intervention improved several measures thought to be related to quality of care and life for NH residents. Significant improvement was also found in the frequency of UI and appropriate urinary toileting, which replicates previous findings. A result not previously reported was that subjects with more cognitive impairment were most responsive to prompted voiding. This finding is

It is likely that the inability of cognitively impaired people to self-initiate behaviors (drinking and toileting requests) influence the problems more than with other residents. Prompting protocols compensate for these self-initiation problems and lead to a higher degree of responsiveness than with other residents whose incontinence may have more complex causes. With regard to FI, although it was found that the appropriateness and frequency of continent bowel movements increased significantly in the intervention than in the control group, the number of FI episodes did not change.

If then focused on the individual with dementia			
IF	THEN	Cross ref and comments	High level theories
<p>If everyone involved in providing care knows that faecal continence is possible for many people with dementia</p> <p>A mid-range theory must be able to be tested.</p> <p>THINK! Resources and response to resources</p>	<p>timely clinician led assessment with linked care planning and treatment, including prompted voiding, will achieve reduced prevalence of FI and pad use, appropriate containment, increased comfort and skin integrity and reduced odour and staff costs</p>	<p><a href="#">Fossey et al. (2006)</a>, <a href="#">Akhtar and Padda (2005)</a>, <a href="#">Board et al. (2012)</a>, <a href="#">Chenoweth et al. (2009)</a>, <a href="#">Coope et al. (2014)</a>, <a href="#">Flanagan et al. (2012)</a>, <a href="#">Fossey et al. (2014)</a>, <a href="#">Flanagan et al. (2013)</a>, <a href="#">Harari et al. (2012)</a>, <a href="#">Heckenberg (2008)</a>, <a href="#">Leung and Schnelle (2008)</a>,</p>	<ul style="list-style-type: none"> <li>Theories of interprofessional working</li> <li>Normalisation theory, coherence and cognitive participation</li> <li>Comprehensive geriatric assessment</li> <li>Person centred care/malignant psychology</li> <li>Implementation theory: Change agent and clinical co-ordinator</li> </ul>
If then statement focused on the organisation of care within a care home			
IF	THEN		
<p>If care home staff are trained and supported, including opportunities for review and reflection with visiting clinicians, and their organisation is incentivised to provide patient centred continence care with the explicit expectation that pads are the solution of last resort</p>	<p>residents with dementia and faecal incontinence will have care plans that include the use of pads only after all other approaches have been exhausted. In addition to resident specific outcomes there will be staff satisfaction and lower staff turnover</p>	<p><a href="#">Fossey et al. (2006)</a>, <a href="#">Chenoweth et al. (2009)</a>, <a href="#">Flanagan et al. (2012)</a>, <a href="#">Fossey et al. (2014)</a>, <a href="#">Harari et al. (2012)</a>, <a href="#">Heckenberg (2008)</a>,</p>	<ul style="list-style-type: none"> <li>Normalisation</li> <li>Institutionalisation/stigma</li> <li>Culture change</li> <li>Leadership: manager</li> <li>Integrated working</li> <li>Incentivisation</li> <li>Person centred care</li> </ul>
If then statement focused on the environment and access to resources			
IF	THEN		
<p>If the care home environment provides en-suite bathrooms, dementia appropriate signage and clothing with access to specialist continence and dementia support services and training &amp; equipment</p>	<p>FI will be assessed, treated and contained appropriately</p>	<p><a href="#">Fossey et al. (2006)</a>, <a href="#">Chenoweth et al. (2009)</a>, <a href="#">Flanagan et al. (2012)</a>, <a href="#">Fossey et al. (2014)</a>,</p>	<ul style="list-style-type: none"> <li>Normalisation theory, en-suite bathroom as normal.</li> <li>PCC embedded in the environment?</li> </ul>

## Realist workshop

- Took diagram and if then statements
- Told it was a bit flat (descriptive only)
- Need resources and response to resources – because mechanism is key
- Took contexts, resources, outcomes from diagram
- Looked at DEF papers and pulled into new M(resource) C M(response) O table – as in the example sent out