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Action on Incontinence

*report of a
working group*

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w ideas. The Centre now

has a broader interest in problems of health and related social care and its permanent accommodation in Camden Town has excellent facilities for conferences and meetings. Allied to the Centre's work is the Fund's Project Committee which sponsors work of an experimental nature.

ACTION ON INCONTINENCE

report of a working group

King's Fund Centre

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Report of the Incontinence Action Group

Incontinence — a widespread human problem throughout history — is gradually receiving public recognition. Previously a taboo subject, except to physicians and nurses, recently and tentatively it is being mentioned in the media. This is part of the increasing recognition that physical and mental disabilities result from structural and functional abnormalities of the body and should reflect neither blame nor shame upon the sufferer.

In the case of incontinence of urine and faeces, this recognition is still small compared to the extent of the problem. The aspects of incontinence that are known about are those in which enthusiastic workers have achieved important developments. Many other problems are still considerably neglected.

The Incontinence Action Group has attempted to consider the whole of this subject with the major objective of encouraging sufferers to report it, and their doctors and nurses to become confidently informed in its management. The Group has considered the knowledge which has become available as a result of careful research and pioneering developments, and the huge gap which exists between available knowledge of the causes and methods of management and that which is actually known to practising nurses and doctors. This represents a failure of basic and postbasic, undergraduate and graduate education.

A dilemma therefore exists between fostering public awareness and demand for treatment on the one hand, and on the other a medical and nursing profession which is largely unable to respond because of its inadequate knowledge. The solution must lie in attacking both horns of this dilemma and this the Incontinence Action Group has attempted to do. This report is the statement of their findings and recommendations.

The Incontinence Action Group

The Incontinence Action Group was set up on the initiative of Mr Clive Charlton in 1981. The membership is shown over the page.

Action on incontinence

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Report of the Incontinence Action Group

The Group's major objectives have been:

- a to increase knowledge about incontinence among all professions concerned;
- b to improve diagnostic and management facilities;
- c to improve the evaluation and supply of appliances;
- d to educate the public about the problems of incontinence and the solutions.

Recommendations

- 1 Medical and nursing schools should consider how and where the subject of continence and incontinence of urine and faeces should be taught in their individual curricula. The subject needs wider treatment in textbooks used by doctors, nurses and students (pages 12 - 13).
- 2 An incontinence clinic with some form of urodynamic assessment should be available to every district (page 14).
- 3 A continence nurse adviser should be established in each health district. To facilitate this, we suggest that each district should set up a committee or a working group, including representatives of nursing, supplies and relevant medical specialities, and the continence nurse adviser would be associated with this group (page 17).
- 4 The Joint Board of Clinical Nursing Studies might consider the appropriate way of setting up a course on the management of incontinence and the promotion of continence (page 17).
- 5 Evaluation of current and future products used in the management of incontinence should be carried out within health districts. It should then be assured that those which are recommended are available to patients both in hospitals and in the community (page 18).
- 6 Greater emphasis on public education as to the causes and management of incontinence is needed. The Health Education Council, the media, chemist shops and organisations such as Age Concern all have a part to play in promoting this awareness (page 20).

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Prevalence of incontinence

The most recent general population study¹ showed a prevalence of urinary incontinence (defined as two or more episodes occurring in the past month) as follows:

Females aged	15 - 64	—	8.5%
	65+	—	11.6%
Males aged	15 - 64	—	1.6%
	65+	—	6.9%

Faecal incontinence in adults aged 15 and above is 0.5 per cent. Only about half of these sufferers have been to their general practitioners or to a hospital clinic.

Within the general population there are special groups particularly prone to incontinence. These include the elderly (as seen in the figures above), women in middle life, sufferers from paraplegia and other diseases affecting the brain and spinal cord, and mentally subnormal persons.

Present knowledge about incontinence

Incontinence is a symptom and not a disease. It may be a symptom of many different diseases and thus has many causes. As with any symptom, no specific treatment can be applied until the cause has been diagnosed. Diagnosis of the cause is therefore the prime necessity.

The cause may lie in any of the anatomical structures involved in the control of micturition and defaecation. These range from the brain through the spinal cord and nerves to the bladder and urethra, the lower bowel and rectum, and the muscles which control and support them. A simplified scheme of causes of incontinence is shown in Appendix 1.

In making a diagnosis it may be necessary to use special tests and the past few years have seen great strides in the development of some of these methods of urodynamic assessment. Most patients can be properly investigated by their general practitioner on the basis of history, clinical examination including rectal examination, and simple investigation (for example, urine culture), or

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through him with the help of a neurologist, gynaecologist, urologist, geriatrician or a specialist in mental subnormality at the district hospital. Sophisticated equipment is needed for only a minority of patients and referrals to special incontinence clinics should be possible for most of such patients (see Appendix 4).

Following diagnosis, treatment may be specific — that is to cure the underlying disease. If this is impossible it may be 'behavioural' — altering behavioural habits — or 'symptomatic' — treating the symptom by special equipment such as pads or appliances. Specific treatment may require the use of medication, surgery, physiotherapy or behavioural therapy, but to be successful this must often be supported by individual counselling, by incontinence recording ('charting') and by skilled nursing. The pads and appliances available for symptomatic treatment are now in such profusion that problems arise in the choice and supply of these. They require careful evaluation and when the choice is made, the most suitable appliances must be uniformly available in the hospital and in the community.

Education

A good basis of knowledge about incontinence and strongly positive attitudes towards its management are essential if doctors and nurses are to be of any help to incontinence sufferers. Such knowledge should be acquired at basic or undergraduate level. In medicine, further study and postgraduate education will follow in specialities such as gynaecology, urology and geriatrics where the management of incontinence is an important part of the specialist workload. However, unless the budding general practitioner has acquired this knowledge and these attitudes as an undergraduate, it is very uncertain that he will acquire them later.

The Group therefore made enquiries as to the amount of teaching on incontinence which is given

- a in the undergraduate medical course;
- b in postgraduate training of general practitioners;
- c in the basic and postbasic training of nurses; and
- d to what extent the subject is dealt with in the relevant textbooks.

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a Medical undergraduate

As might be expected, the nature and quantity of teaching varies considerably from one medical school to another. Questionnaires were sent to 12 professors of physiology and the 11 who replied indicated a range of teaching on processes of micturition and defaecation ranging from part of one lecture to a total of three hours. Seven of the 11 schools had set examination questions in one or both of the topics in the previous five years – and others included questions in multiple choice examinations.

In the clinical years the major part of teaching in the subject is in the geriatric medicine course, and this varies enormously. Only 13 of the 29 medical schools in Great Britain have an academic department of geriatric medicine at present and these have the greatest amount of teaching. Altogether, teaching in the whole field of geriatric medicine varies from almost nil to 80 hours. Teaching about incontinence in geriatric medicine was the subject of a survey, the results of which are shown in Appendix 2. This shows a mean time of 71 minutes on urinary incontinence and 21 minutes on faecal incontinence in the geriatric medicine course.

Teaching medical undergraduates about incontinence also takes place in urology departments of medical schools, and a survey of 23 schools with consultant urologists showed that ten gave one formal lecture on the subject of urinary incontinence, and that the place of urodynamic assessment was discussed in teaching in 19 schools. Only 8 of the 23 urologists thought that teaching on the subject was adequate.

In gynaecology, the specific condition of stress incontinence due to weakness of the pelvic floor and bladder outlet is dealt with in the undergraduate curriculum.

Members of the International Continence Society practising in urology or obstetrics and gynaecology were asked about their involvement in the teaching of medical students and student nurses. Information was obtained from 40 centres, 27 of which taught medical students and 22 taught student nurses. The teaching to medical students was an average of 55 minutes and included 22 urologists, 13 gynaecologists and two paediatric surgeons. In most cases this teaching is on a 'firm' or 'unit' basis. It would not affect all medical

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students in that particular medical school but only those attached to the firm or unit concerned, and probably amounting to only 25 per cent of the students.

b Postgraduate training of general practitioners

Enquiries were also made about the postgraduate vocational education of general practitioners before they become full-time principals. Seventy-six replies were received from course organisers, and the indication was that most entrants to general practice picked up knowledge about urinary incontinence in an *ad hoc* fashion. The main source from which the trainee general practitioners were assumed to gain specific instruction was in geriatric units if they served as senior house officers and from community nurses attached to the teaching practices. Incontinence was dealt with specifically in only 13 per cent of courses run by these course organisers.

c Nurse education

Questionnaires were sent to 203 directors of nurse education and replies received from just over half (113). All schools replying indicated that nurses receive education on incontinence in their introductory block and that it is covered in the sections on basic nursing care. It also receives variable mention in lectures by consultant urologists, gynaecologists and geriatricians. Incontinence is also dealt with in tutorials (maximum of three) and during the ward experience. Aids and appliances are considered during community experience. Many directors felt that inadequate teaching was given on the promotion of continence (in distinction to the management of incontinence).

Pupil nurses have much less teaching on incontinence. It is covered in a maximum of one consultant lecture and two tutorials. Their community experience is limited to one day – with little opportunity to consider aids and appliances.

Nurse teachers Twenty-four institutions offering either a six-month clinical teacher course or one-year nurse-tutor course were approached, and twelve replies were received. Together they train 225 clinical teachers and over 100 nurse tutors a year. Of the twelve courses, one had formal lectures on incontinence (three hours on the physiology and disordered function of micturition) and two others had lectures on related topics (physiology of normal micturition and urology).

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Four colleges indicated that students might learn about incontinence during their teaching practice if this was on a geriatric or mental subnormality placement, but the consensus was that nurse teachers' courses were concentrating on education theory and did not teach on specific subjects.

A number of health visitor courses include some teaching on incontinence, usually from a geriatrician.

In postbasic nurse education, incontinence figures in the short (22 day) and long (5½ months) courses in geriatric nursing, and there is also a good deal about bladder control and continence in the six-months course on behaviour modification for nurses in the field of mental subnormality.

Films and the occasional lecture on incontinence also occur in some hospital study days.

Overall it appears that while there are notable exceptions, in general medical students and student nurses receive very little structured and considered teaching on the causes and management of incontinence.

Recommendation

We recommend therefore that medical and nursing schools should consider how and where the subject of incontinence of urine and faeces should be taught in their curricula.

d Textbooks

The amount of space devoted to incontinence in the main medical textbooks and books for students was reviewed. Details are shown in Appendix 3. Of the seven principal textbooks of general medicine, the subject of bladder and bowel control and incontinence varies from three pages in Brackenridge's *Essential Medicine* (total 442 pages) to one paragraph in *The Principles and Practice of Medicine* edited by Harvey, Johns, McKusick, Owens and Ross (total 1540 pages). Textbooks of general practice devote two to three pages out of 600 - 700, and textbooks of geriatric medicine 12 - 20 pages out of 700 - 800. The subject is dealt with in most detail in small books of geriatric medicine intended for students — of which eight were reviewed — the amount of space devoted to the subject ranging from 3 to 20 pages. Ten textbooks of obstetrics

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and gynaecology were reviewed and nine of them discuss incontinence, varying from 1 page to 20 pages. One of these (*Gynaecology Illustrated* by Garrey et al, 1978) gives an excellent presentation both of the subject of incontinence and of urodynamics.

The large textbooks of surgery (for example, Bailey and Love's *Surgery*, 18th edition, 1981, and Davies and Christopher's *Surgery* edited by Sabiston, 1981) generally give short accounts of the definition and classification of urinary incontinence but no practical details of its management. Some deal more extensively with faecal incontinence.

The subject is dealt with in much more detail in recent textbooks of urology. *Urology*, edited by Geoffrey Chisholm (1980) has a chapter on the subject by Keith Yeates. John Blandy's *Urology* (1976) has a chapter by Lynn Edwards. *Dynamics of the Urinary Tract* by Norman Gibbon and Keith Parsons deals extensively with the subject.

Students' books of surgery devote some space and deal in some detail with investigation and assessment of urinary incontinence in general.

Nursing textbooks The treatment of this subject in nursing textbooks is detailed in Appendix 3. Again, the subjects are given greatest emphasis in nursing textbooks relating to the elderly (range of 2 - 27 pages). Space devoted to incontinence in general nursing textbooks varies between ½ to 6 pages, though some deal more extensively with catheter management.

Specific texts on incontinence Numbers of these have appeared in the last decade. Some are listed in Appendix 3.

Recommendation

More space should be devoted to the subject of incontinence in general medical and nursing textbooks.

Diagnostic facilities

There have been considerable developments in the electronic recording of urodynamic measurements over the last few years and these have led to

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increasing precision in diagnosing the causes of incontinence of urine. To provide this diagnostic service it is usually necessary to set up a special clinic. A number of these are now functioning in the country. In an attempt to survey all the clinics presently available, a questionnaire was circulated to all the UK members of the International Continence Society. Of 98 sent out, 68 replies were received and these related to 37 different urodynamic assessment clinics. There is thus a minimum of 37 clinics. The full list of these is shown in Appendix 4. The majority are run by urologists (28) and/or gynaecologists (20); 17 are held once weekly, 7 three times a week and 11 daily or more often. Two are held less than once a week.

Specialities represented are as follows: urology — 28, gynaecology — 20, geriatrics — 4, radiology — 3, paediatric surgery — 2, clinical scientist — 2, spinal injuries specialist — 1.

In addition to these specific clinics, many urologists and gynaecologists will carry out a urodynamic assessment when it is indicated in an individual patient. Since this survey was undertaken, further clinics have been developed.

Recommendations

We consider that an incontinence clinic with some form of urodynamic assessment should be available in each district. This is most likely to be associated with the departments of urology and gynaecology but others, including geriatricians, may be involved in running it.

Management

Nurse specialist (resource nurse)

Over the past few years an increasing number of nurses have taken a particular interest in the management of incontinence and, in a number of districts, nurses specialising in one or more aspects of this problem have been appointed. In most cases these nurses have started their work as part of an incontinence or urodynamic assessment clinic. They have become involved in counselling patients attending that clinic, particularly in relation to the use of pads and appliances. It has become apparent to these nurses that the availability of such appliances is haphazard, and this in turn led them to set up clinical trials to determine the appliances which are most satisfactory. In most cases, the whole

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of this activity has been funded and carried out on a research basis. However, it has become quite clear to clinicians involved in these clinics that the nurse specialist has an invaluable role, not only in research but also in promoting knowledge about incontinence among nurses and others, in rationalising the supply of equipment in the hospitals or districts, in counselling individual patients and by promoting a behavioural approach to management. A number of studies have attempted to evaluate the role of the incontinence nurse specialist herself.² An Association of Continence Nurse Advisers has been established and its first national conference was held in Newcastle-upon-Tyne in 1982 and was attended by 120 nurses. Not all of these were specialists but all of them had an interest in developing some special expertise in this area.

The Group has carried out a number of surveys to assess the present status of nurses who specialise, in whole or in part, in advising on the management of incontinence.

A questionnaire was sent to 176 district nursing officers in England and Wales and 154 replies were received. In 18 of these districts (12 per cent), a nurse or other professional person was in post as an incontinence adviser. This included 11 nursing officers (seven in the community and four in geriatrics), two specialist incontinence nurses, two incontinence and stomatherapists, among others. A further 46 districts (30 per cent) had someone who unofficially adopted the role of incontinence adviser as part of her duties. In some cases more than one nurse in the district was concerned. A great majority were nursing officers or senior nursing officers and 17 of them were in geriatrics.

Questionnaires were sent to those named by their district nursing officers as an official or unofficial incontinence adviser and 60 replies (80 per cent of those sent) were received and analysed. Of these, nine were appointed as specialists (seven continence advisers, one stomacare sister, one infection control SNO). Altogether 11 had a role as continence adviser written into their job description, and the remaining 49 had taken it on either because of personal interest (33) or for other reasons. Twenty-eight were involved in hospital only and 20 in the community only. Their activities were concerned particularly with patients (27), relatives (21), supplies officers (24), social services (8) and doctors (5). Twenty-four of them gave formal talks, lectures or demonstrations of aids to groups (principally nurses). Twenty-four said that they had no

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medical back-up at all; 29 had the interest of a consultant (usually a geriatric physician); eight had access to incontinence/urodynamic units. Seven were involved in working parties considering the problems of incontinence within their own districts, and seven were involved in carrying out trials.

Additional information has been received from the Association of Continence Nurse Advisers which would suggest that the present situation in the UK is as follows:

17 full-time continence advisers;

9 part-time continence advisers;

10 research nurses;

6 nurses working outside the National Health Service structure;

42 TOTAL.

Some of the nurse specialists in incontinence have become nationally recognised authorities as a result of their research work and publications. Others have developed a local service which is highly valued and greatly sought after.

In 1977 the Chief Nursing Officer, Dame Phyllis Friend DBE, sent to area, district and divisional nursing officers and those responsible for nurse education, a letter on the standards of nursing care services on the subject of promotion of continence and management of incontinence (CNO(SNC)(77)1). In this she said:

'It is generally accepted that the promotion of continence and the management of the problems of incontinence are matters of particular concern to the nursing profession and require services in which nurses in all fields and of all categories have a major contribution to make.'

She recommended that the management of incontinence should be identified as the particular responsibility of an appropriate nursing officer who would act as a point of reference to nurses and health visitors in all fields of the service.

The Group noted that while there is a difference in emphasis between a nursing

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officer acting as a resource person and a nurse specialist or adviser fulfilling this role, nevertheless, the intention of both endeavours is the same. While a variety of such nurse specialists exists (for example, control of infection, stomacare, behaviour modification and so on) the ideal aim is that all nurses should be expert in incontinence management. The Group acknowledges that this should be the long-term aim, but at present it is so far from being fulfilled that the majority of members of the Group believe that an essential step in this direction is the development of a continence adviser in every district. The nurse adviser may be involved in hospital, in the community or both, may be full-time or part-time and there may be one or more per district. Where there is an incontinence/urodynamic clinic, the adviser would, with advantage, be associated with this. The adviser should have a clinical role with individual patients but her main role would be that of a resource person to promote the optimal management of incontinence and promotion of continence by all nurses, to evaluate equipment and to facilitate its general availability in the district, and to set up and advise on a system of incontinence recording.

Both inpatients and outpatients should have easy and rapid access to the nurse advisers.

Recommendations

That a continence nurse adviser be established in each health district. To facilitate this, we suggest that each district should set up a committee or a working group, including representatives of nursing supplies and relevant medical specialities, and the continence nurse specialist would be associated with this group.

We suggest also that the Joint Board of Clinical Nursing Studies might consider the appropriate way of setting up a course on the management of incontinence and the promotion of continence.

Aids and equipment

We have identified 102 different companies involved in the manufacture and distribution of incontinence appliances, including garments and pads. These include 28 involved in body-worn protective garments and pads, 23 in body-worn drainage bags, 20 in bed/chair protection, 21 in male appliances, 17 in

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bedside drainage bags and 16 in fixation methods for sheaths. In the face of such a bewildering range of products, how is the patient to get good advice — and indeed who is to decide what stocks should be held?

If all nurses and physicians concerned make their own decisions — most probably based on one or two products that they have experience of and which in turn have probably been introduced by trade representatives — then demands for a huge variety of such appliances will come to the district supplies officer. He will probably exercise final judgment based not on the usefulness of the product but rather on its cost. Furthermore, the equipment which is available in hospital may not be available in the community, so that patients trained to use one appliance while in hospital may find it unavailable when they go home. Indeed, this complex difficulty in supply may be reflected more centrally through the committees of the Department of Health and Social Security involved in approving such appliances.

An evaluation of current and future products used in the management of incontinence is therefore absolutely essential, and it is suggested that the district working party referred to above should take on this responsibility and make decisions for the district based on evaluations carried out by the continence adviser.

There have been few well conducted trials of aids and appliances for the management of incontinence. A short bibliography is given in Appendix 5 and guidelines on aids and equipment in Appendix 6. It would seem essential that research-funding agencies should turn their attention to encouraging the development of research in this field.

Recommendations

Evaluation of current and future products used in the management of incontinence should be carried out within health districts. It should then be assured that those which are recommended are available to patients both in hospitals and in the community.

Education of the public

The prevalence of incontinence which has not been reported by the sufferers

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to doctors or nurses was recorded in the study by Thomas and colleagues.¹
This showed the scale of recognised and unrecognised incontinence as follows:

		<i>Recognised</i>	<i>Unrecognised</i>	<i>Total</i>
Male	15 - 64	0.1%	1.5%	1.6%
	65+	1.3%	5.6%	6.9%
Female	15 - 64	0.2%	8.3%	8.5%
	65+	2.5%	9.1%	11.6%

In the face of this enormous burden of unreported incontinence, there is obviously great need for information to be made available to the public as to methods that may be useful to them in helping themselves and in the importance of seeking professional assistance in diagnosing the cause of the problem.

The kind of advice which would be helpful to such persons and which might be available through community nurses and general practices is shown in Appendix 7.

Additional information in the form of simple leaflets should be made widely available through chemists, general practitioners' surgeries, outpatients departments, and so on. Such material could also be distributed through organisations such as Age Concern, with their access to clubs, day centres and other places frequented by elderly people who may be reluctant to seek help if they have incontinence problems. The Health Education Council might be further involved in these activities.

Manufacturers of incontinence pads and other aids need encouragement to advertise their products more openly, bearing in mind that the market for their products is potentially greater than that for disposable baby napkins. Open display of a range of incontinence aids and garments is needed in retail chemist shops. Similarly, television and radio companies should include more frequent references to the problems, possible solutions and aids to incontinence in drama scripts and soap operas, as well as including this topic more often in documentary programmes.

Regular seminars and conferences would be helpful for people working in the

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community who have contact with sufferers of incontinence. Frequent reminders by those who work on behalf of elderly and disabled people that this subject needs to be more widely discussed, should be made to pharmacists and others who are in close contact with people likely to suffer from this distressing condition. Meetings to promote general awareness and to describe practical responses might be sponsored by organisations such as Age Concern.

Recommendations

Greater emphasis on public education as to the causes and management of incontinence is needed. The Health Education Council, the media, chemist shops and organisations such as Age Concern all have a part to play in promoting this awareness.

Acknowledgement

We are grateful to Mr David Syme and David Hobman who joined us to discuss behavioural therapy and public education respectively.

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- 2 Ramsbottom F. Is advice really cheap? *Journal of Community Nursing*, 1982, vol 5, no 11, 9 - 10, 16.

Appendix 1

Causes of urinary incontinence

<i>Anatomical site</i>	<i>Disease process</i>	<i>Type of incontinence</i>
Brain	Imperfect development or birth injury – continence never acquired	uncontrolled micturition
	Psychological impairment of control mechanism	urge incontinence
	Organic disease developing after continence acquired	urge incontinence
	– stroke – dementia – tumour, and so on	
Spinal cord	Paraplegia, multiple sclerosis, disc lesion, spinabifida, and so on	uncontrolled micturition
Autonomic nerves	Diabetes, tumours of cauda equina, drug effects	overflow incontinence
Bladder	Tumour, stone, infection	urge incontinence
	Fistula developmental abnormality	dribbling or stress incontinence
Bladder outlet and pelvic floor	Muscle weakness	stress incontinence
Urethra	'Urethritis'	urge incontinence
	Stricture, prostatic enlargement urological trauma, constipation	overflow incontinence

Also in association with environmental and locomotor difficulties.

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Causes of faecal incontinence

<i>Anatomical site</i>	<i>Disease process</i>	<i>Type of incontinence</i>
Brain	Imperfect development or birth injuries – continence never acquired	uncontrolled defaecation
Brain or spinal cord	Organic disease developing later after continence acquired	reflex incontinence
Colon and rectum	Any disease causing diarrhoea	urge incontinence
	Constipation	overflow incontinence
Pelvic muscles	Weakness and neuronal degeneration	stress incontinence

Appendix 2

Teaching about incontinence in geriatric medicine (time in minutes)

Incontinence of urine

<i>12 schools (all with professorial departments)</i>	<i>Lectures</i>	<i>Tutorials/ seminars</i>	<i>Films/ Videos</i>	<i>Other</i>	<i>Total</i>
1 Cardiff	—	30	—	+	30+
2 Newcastle	60	—	—	+ O & G Urology	60+
3 Manchester	75	60	30	+	165+
4 St George's Hospital	60	—	—	+ O & G Urology	60+
5 Edinburgh	—	45	—	45	90
6 University College Hospital, London	—	45	—	45	90
7 Belfast	—	30	30	+	60
8 Liverpool	—	45	—	30	75
9 Nottingham	—	60	—	15	75
10 Glasgow	35	15	—	—	50
11 Southampton	—	60	—	+ Urology	60+
12 Birmingham	—	90	—	—	90
Number of departments	4	10	2	10	
Average length	60	50	30	30	
Average 75+ minutes	Range 30+ – 165+				

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Incontinence of urine continued

<i>Teaching hospitals (non-professorial)</i>	<i>Lectures</i>	<i>Tutorials/ seminars</i>	<i>Films/ Videos</i>	<i>Other</i>	<i>Total</i>
13 Charing Cross Hospital	30	20	—	—	50
14 London Hospital	—	—	—	—	—
15 Middlesex Hospital	—	45	—	—	45
16 St Bartholomew's Hospital	45	—	+	—	45+
17 Aberdeen	15	60	—	60 (Dem)	135
18 Sheffield	45	—	—	—	45
19 Oxford	—	60	—	—	60
20 Leicester	—	50	—	—	50
Number of departments	4	5	1	1	
Average length	34	48			
Average 53 minutes	Range 45 — 135				
Total 20 schools	Mean 71 minutes				

Appendix 2

Incontinence of faeces

<i>12 schools (all with professorial departments)</i>	<i>Lectures</i>	<i>Tutorials/ seminars</i>	<i>Other</i>	<i>Total</i>
1 Cardiff	—	30	+	30+
2 Newcastle	—	—	15	15
3 Manchester	—	45	—	45
4 St George's Hospital	30	—	—	30
5 Edinburgh	—	45	—	45
6 University College Hospital, London	—	30	—	30
7 Belfast	—	10	—	10
8 Liverpool	—	15	—	15
9 Nottingham	—	15	—	15
10 Glasgow	—	15	+	15+
11 Southampton	—	15	—	15
12 Birmingham	—	—	15	15
Number of departments	1	9	4	
Average length	30	24	15	
Average 23+ minutes	Range 10 — 45			

<i>Teaching hospitals (non-professorial)</i>	<i>Lectures</i>	<i>Tutorials/ seminars</i>	<i>Other</i>	<i>Total</i>
13 Charing Cross Hospital	15	—	—	15
14 Middlesex Hospital	—	15	—	15
15 St Bartholomew's Hospital	15	—	—	15
16 Aberdeen	5	10	—	15
17 Sheffield	15	—	—	15
18 Oxford	—	15	—	15
Number of departments	4	3		
Average length	12.5	13		
Total 18 schools	Mean 21 minutes			

Appendix 3

Amount of space devoted to incontinence of urine and faeces in various textbooks

Textbooks of general medicine

Essential Medicine, 2nd edition, by Brackenridge

442 pages

innervation of the bladder, incontinence of urine and faeces — 2 pages

incontinence in the elderly — 1 page

treatment of incontinence in coma — 1 paragraph

Principles of Internal Medicine, 9th edition, by Harrison

985 pages

urinary incontinence — 2 pages

Principles and Practice of Medicine, 12th edition, by Davidson

978 pages

urinary incontinence with mention of faecal incontinence dealing with neurogenic aspects only — 1 page

Principles and Practice of Medicine, 20th edition, edited by Harvey, Johns, McKusick, Owens and Ross

1540 pages

incontinence of urine — 1 paragraph (with 4 references)

Textbook of Medical Treatment, 14th edition, by Alstead and Girwood

520 pages

incontinence in old age — $\frac{3}{4}$ page

neurogenic bladder — $1\frac{1}{2}$ pages

faecal incontinence — 1 paragraph

Appendix 3

Textbook of Medicine, 5th edition, by Cecil

2355 pages

urinary incontinence — $\frac{1}{2}$ page (in paraplegia)

faecal incontinence — $\frac{3}{4}$ page

Textbook of the Practice of Medicine, 12th edition, by Price, edited by Bodley Scott

1495 pages

incontinence in stroke — 3 paragraphs

incontinence in elderly — $\frac{1}{2}$ page

Textbooks of general practice

Scientific Foundations of Family Practice, by Fry, Gambrill and Smith

680 pages

incontinence of urine — $1\frac{1}{2}$ pages

faeces — $\frac{1}{2}$ page

Textbook of Medical Practice (A), by Fry, Byrne and Johnson

662 pages

catheter management — $1\frac{1}{2}$ pages

paraplegia — 1 paragraph

in care of the aged — $\frac{3}{4}$ page

in care of the dying — 1 page

total 4 pages

Textbooks of geriatric medicine

Clinical Geriatrics, 2nd edition, edited by Rossman

702 pages

urinary incontinence — 10 pages

faecal incontinence — 2 pages

Action on incontinence

Essential of Geriatric Medicine, 2nd edition, by G F Adams

146 pages

incontinence — 7 pages

Geriatric Medicine for Students, 2nd edition, by Brocklehurst and Hanley

236 pages

incontinence of urine — 16 pages

incontinence of faeces — 4 pages

Geriatrics, by Exton-Smith and Overstall

340 pages

incontinence of urine — 10 pages

incontinence of faeces — 2 pages

Lecture Notes in Geriatrics, 2nd edition, by Coni, Davison and Webster

340 pages

incontinence — 15 pages

Medical Care of the Elderly, by Hall, McLennan and Lye

159 pages

incontinence — 10 pages

Outline of Geriatrics, 2nd edition, by Hodkinson

166 pages

incontinence — 3 pages

Practical Geriatrics, by von Hahn

446 pages

incontinence of urine — 7 pages

incontinence of faeces — 3 pages

Appendix 3

Practical Management of the Elderly, 3rd edition, by W F Anderson

450 pages

incontinence of urine – 9 pages

incontinence of faeces – 4 pages

Textbook of Geriatric Medicine and Gerontology, 2nd edition, edited by Brocklehurst

835 pages

incontinence of urine – 17 pages

incontinence of faeces – 3 pages

Textbooks of gynaecology

Fundamentals on Obstetrics and Gynaecology, vol 2, *Gynaecology*, by Llewellyn Jones, 1978 – 3 pages

Gynaecology, by Holmes, 1965 – 3 pages

Gynaecology Illustrated, by Garrey et al, 1978 – 20 pages

Gynaecology by Ten Teachers, by Clayton, 1980 – 4 pages

Integrated Obstetrics and Gynaecology for Postgraduates, by Dewhurst, 1981 – 16 pages

Lecture notes on Gynaecology, by Barnes, 1980 – 1 page

Obstetrics and Gynaecology, by Taylor and Brush, 1978 – none

Pocket Gynaecology, by Clayton and Newton, 1979 – 2 pages

Principles of Gynaecology, by Jeffcoate, 1975 – 30 pages

Shaw's Gynaecology, by Howkins and Bourne, 1971 – 10 pages

Action on incontinence

Nursing textbooks related to the elderly

Aged Person and the Nursing Process (The), by A G Yurick et al, Appleton—Century—Crofts, 1980

urinary and faecal incontinence — 5 pages

Caring for Elderly People, by S Hooker, Routledge and Kegan Paul, 1976

urinary incontinence — 4 pages

faecal incontinence — 1 page

Eldercare: A Guide to Clinical Geriatrics, edited by O'Hara—Devereaux et al, 1981

urinary incontinence — 2½ pages

catheter care — 1 page

Geriatric Care (Nursing Modules), by F R McLeod, HM+M, 1976

urinary and faecal incontinence — 6 pages

Geriatric Nursing (Modern Practical Nursing Series), by E M Burns et al, 1973

urinary incontinence — 7 pages

faecal incontinence — 4 pages

Geriatric Nursing, by C Eliopoulos, Harper and Row, 1979

urinary incontinence — 2 pages

Geriatric Nursing, 2nd edition (Nursing Aids Series), by A M F Storrs, Bailliere Tindall, 1980

general incontinence — 2 pages

urinary incontinence — 17 pages

faecal incontinence — 5 pages

Geriatrics for Nurses and Social Workers, 2nd edition, by J Agate, Heinemann Medical, 1979

urinary and faecal incontinence — 2 pages

Appendix 3

Gerontology and Geriatric Nursing, by Ferguson Anderson et al, Hodder and Stoughton, 1982

urinary incontinence — 6 pages

faecal incontinence — 1 page

Newton's Geriatric Nursing, 5th edition, by H C Anderson, Mosby, 1971

urinary and faecal incontinence — 1 page

Nursing and the Aged, 2nd edition, by I M Burnside, McGraw-Hill, 1981

urinary incontinence — 27 pages

faecal incontinence — ½ page

Nursing Process in Later Maturity(The), by R Murray et al, Prentice Hall, 1980

urinary and faecal incontinence — 3 pages

Nursing Management for the Elderly, edited by D L Carnevali and M Patrick, Lippincott, 1979

catheter care — 1½ pages

urinary incontinence — 11 pages

faecal incontinence — ½ page

Older Patient: A Textbook of Geriatrics (The), 3rd edition, by R E Irvine et al, Hodder and Stoughton, 1978

urinary incontinence — 8 pages

faecal incontinence — 7 pages

Toward Health Aging, by P Ebersole and P Hess, Mosby, 1981

urinary incontinence — 4 pages

faecal incontinence — 1 page

General nursing textbooks

Basic Nursing, 4th edition, by E Bendall and E Raybould, Lewis, 1977

urinary incontinence — 4 pages

faecal incontinence — 2 pages

Action on incontinence

Basic Nursing: A Psychophysiological Approach, by K C Sorensen and J Luckmann, Saunders, 1979

urinary incontinence — 2 pages
catheterisation and management — 10 pages
faecal incontinence — 1 page

Clinical Nursing, 4th edition, by I L Beland and J Y Passos, Macmillan, 1981

urinary incontinence — 1 page

Elements of Nursing, by N Roper et al, Churchill Livingstone, 1980

catheter management — 1 page
urinary and faecal incontinence — 4 pages

Fundamentals of Nursing, 2nd edition, by M Murray, Prentice-Hall, 1980

urinary incontinence — 3 pages

Fundamentals of Nursing, 6th edition, by L Wolff et al, Lippincott, 1979

urinary incontinence — 3 pages
catheterisation and management — 10 pages
faecal incontinence — 1 page

Integrated Basic Theory and Practice of Nursing, by B M Ibell, Pitman Medical, 1979

urinary incontinence — ½ page

Introduction to Nursing, 5th edition, by M Spencer and K M Tait, Blackwell Scientific, 1981

urinary incontinence — 1 page
catheterisation — 3 pages
faecal incontinence — 1 page

Medical-Surgical Nursing, 6th edition, edited by K N Shafer et al, Mosby, 1975

urinary incontinence and catheter management — 8 pages
faecal incontinence — 3 pages

Appendix 3

Nursing: Levels of Health Care Intervention, by A W Burgess, Prentice-Hall, 1978

urinary incontinence – 3 pages

Textbook of Medical-Surgical Nursing, 4th edition, by L S Brunner and D S Suddarth, Lippincott, 1980

bladder and bowel training – 1 page

catheterisation – 1 page

Understanding Nursing Care, 2nd edition, edited by A M Chilman and M Thomas, Churchill Livingstone, 1981

urinary incontinence and catheter management – 8½ pages

faecal incontinence – ½ page

Specific texts on incontinence

Female Urinary Incontinence, by S L Stanton, Lloyd-Luke, 1977 – 118 pages

Incontinence and its Management, by D Mandelstam, Croom Helm, 1980
– 233 pages

Incontinence in the Elderly, by F L Willington, Academy Press, 1976

urinary and faecal incontinence – 254 pages

Nursing the Incontinent (Nursing in Depth Series), by E Edmonson, Butterworths

urinary and faecal incontinence – 60 pages

Urinary Incontinence, by K P S Caldwell, London Sector, 1975 – 172 pages

Urinary Incontinence, by E J McGuire, Grune and Stratton, 1981 – 167 pages

Appendix 4

UK incontinence/urodynamic clinics in 1981

Accrington	Accrington Hospital, Northumberland
Bath	Royal United Hospitals
Bristol	Manor Green Hospital
Basingstoke	Basingstoke and District Hospital
Burnley	Burnley General Hospital
Caerphilly	District Miner's Hospital
Cambridge	Addenbrooke's Hospital
Dundee	Royal Infirmary
Exeter	Royal Exeter and Devon Hospital (Walford)
Glasgow	Western Infirmary
	Southern General Hospital
Edinburgh	Royal Infirmary
Hove	Hove General Hospital
Leicester	The General Hospital
Liverpool	Royal Liverpool Hospital
London	Chelsea Hospital for Women
	St Bartholomew's Hospital
	St Peter's Hospital and Institute of Urology
	Westminster Hospital
	University College Hospital (St Pancras Hospital)
	Royal Free Hospital
	Middlesex Hospital
	The London Hospital
	Kings College Hospital
	Guy's Hospital
	St Thomas' Hospital
	St George's Hospital
Manchester	St Mary's Hospital/Royal Infirmary
	University Hospital of South Manchester
Nottingham	University Hospital
Newcastle-upon-Tyne	Freeman Hospital

Appendix 4

Norwich	Norfolk and Norwich Hospital
Oxford	Churchill Hospital
Sheffield	Lodge Moore Hospital
Stirling	Stirling Royal Infirmary
Southampton	Southampton General Hospital

Appendix 5

Review of literature on incontinence aids

Pads and pants

There have been many articles in the nursing press on incontinence aids. Kanga is the most commonly mentioned garment, followed by Mölnlycke. No other garment is consistently mentioned.

Trials have been limited in sample population size, type of patient and range of garments. In hospital, Tam et al¹⁴ found Mölnlycke superior to Kanga with female psychogeriatric patients in that they were cheaper and the nurses preferred them. Watson¹⁸ found Mölnlycke superior to underpads with long-stay patients because they were cheaper and the nurses thought that the patients were more comfortable.

For community patients, Shepherd and Blannin¹¹ tried Kanga, Mölnlycke and plastic pants. They found Kanga superior, but stressed that choice must be individual and the need for a range of products. Norton (in press) tried Kanga, Mölnlycke, Polyweb, Brevet and plastic pants with female outpatients. Problems were encountered with all types. Kanga were the most popular overall, followed by Brevet, but again it was found that to suit everyone a range of products must be available.

Schofield¹⁰, Smith¹³ and Underwood¹⁷ have all found the gelulose pad suitable to 'dribblers' but its use does not seem to be widespread (possibly because of cost).

Underpads

Ramsbottom⁹ has made an extensive review of the literature on underpads. She concludes that nursing texts offer little by way of criteria for their use, instructions on how to use them or definition of the purposes they should serve. The DHSS specification states 'the underpad should provide protection for underlying bedding, thereby dispensing with the need for waterproof sheets and drawsheets'.

Of disposable bed pads, trials agree that only the 10-ply Polyweb pad matches up to specifications (for example, Henderson and Rogers⁵, Tong et al¹⁶, and Lothian et al⁸).

The Kylie, a washable drawsheet for incontinence, has received considerable attention recently. Thomas and Hubbard¹⁵ found in laboratory testing that it was the only pad to keep a dry surface when wet. Smith¹² found the Kylie saved costs in community and hospital use. Burton² and Broughton¹ were both favourable about its use in hospital.

Collection devices

There have been no comparative trials of male or female devices. Most articles merely describe a new device and its use, sometimes giving the numbers who have tried it.

Fielding and Wells⁴ have reported unfavourably on the use of a female device for elderly women.

Male urinals are almost exclusively reported in neurologically damaged patients. No conclusions can be drawn about the best method because no comparisons are made, although there have been some reports of necrosis from bad technique (for example, Fauer and Morrow³).

Indwelling catheters – recent studies

Kennedy and Brocklehurst⁷ and Kennedy⁶ have described problems in the use of indwelling catheters in the management of incontinence, and some solutions.

References

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- 2 Burton B. Keeping the incontinent patient dry. *Nursing Mirror*, 1979, vol 148, no 22, 25 - 26.
- 3 Fauer R and Morrow J W. External urinary devices: use and abuse. *Urology*, 1978, vol 11, no 2, 180 - 182.

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- 4 Fielding P and Wells T J. Urinary collecting device: a clinical trial among female geriatric patients. *Nursing Times*, 1975, vol 71, no 4, 136 - 137.
- 5 Henderson D J and Rogers W F. Hospital trials of incontinence underpads. *Nursing Times*, 1971, vol 67, no 5, 141 - 143.
- 6 Kennedy A. Incontinence advice 1. Long-term catheterisation. *Nursing Times*, 1983, vol 79, no 17, 41 - 45.
- 7 Kennedy A P and Brocklehurst J C. The nursing management of patients with long-term indwelling catheters. *Journal of Advanced Nursing*, 1982, vol 7, no 5, 411 - 417.
- 8 Lowthian P T, Mennie B, Egan M and Meade T W. Underpads for preventing pressure sores. *Nursing Mirror*, 1977, vol 144, no 10, 66 - 69.
- 9 Ramsbottom F J. Toileting and changing elderly patients in hospital. Birmingham, University of Birmingham, Department of Geriatric Medicine, 1980.
- 10 Schofield D. Management of urinary incontinence. *Nursing Mirror*, 1970, vol 131, no 8, 39 - 40.
- 11 Shepherd A M and Blannin J P. A clinical trial of pants and pads used for urinary incontinence. *Nursing Times*, 1980, vol 76, no 23, 1015 - 1016.
- 12 Smith B. A dry bed — and save on costs. *Nursing Mirror*, 1979, vol 148, no 22, 26 - 29.
- 13 Smith P H. Incontinence pads containing carboxymethylcellulose. *Practitioner*, 1971, vol 207, no 1241, 644 - 648.
- 14 Tam G, Knox J G and Adamson M. A cost-effectiveness trial of incontinence pants. *Nursing Times*, 1978, vol 74, no 29, 1198 - 1200.
- 15 Thomas S and Hubbard J K. A laboratory evaluation of incontinence underpads. *Nursing Times*, 1979, vol 75, no 26, 1136 - 1139.

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- 16 Tong D P, Moseley C R and Belcher W H, Comparative evaluation of the cost and comfort of bed pads. *Health and Social Service Journal*, 1973, vol LXXXIII, no 4336, 1202 - 1203.
- 17 Underwood R. Cellulose gel pads in the control of incontinence of urine. *Practitioner*, 1970, vol 205, no 1226, 224 - 225.
- 18 Watson A G. A trial of Mölnlycke pants and diapers. *Nursing Times*, 1980, vol 76, no 23, 1017 - 1019.

Appendix 6

Guidelines on aids and equipment

The choice of aids used must depend on comprehensive assessment of patient.

Distinction must be made between:

- 1 aids to maintaining continence;
- 2 aids to alleviate intractable incontinence.

Aids to maintaining continence

- 1 Equipment to facilitate use of lavatory, for example, raised seats, support rails, and so on.
- 2 Substitute toilet facilities, such as commodes.
- 3 Personal urinals, both male and female, suitable for independent use.

Aids to alleviate incontinence

- 1 Protective pads and pants.
- 2 Bed protection.
- 3 Urinary collection devices.

Pads and pants

There is no single product that meets all needs. There is a wide range available, varying in design and degree of absorbency. Choice *must* relate to individual patient need, and give consideration to occasion and amount of leakage. Other points to be borne in mind are:

- whether patient is mobile, or in bed;
- whether for day or night use;
- whether for urinary, faecal or double incontinence;
- whether patient can manage independently, or requires assistance.

Bed pads

Many are supplied which do not meet DHSS specification; these are to be avoided as inadequate, and as a false economy. Bed pads are totally unsuitable to be cut up and used with pants, although this malpractice is widespread.

Collection devices

Catheters As well as the standard range, short catheters for females and small catheters suitable for self-catheterisation are obtainable.

Bags and holders There are bags of varying capacity, to be attached to the leg by straps or fabric leg-holder, or supported in a waistbelt. Many of these are used with urinary appliances (which are on prescription) as well as with catheters.

Supplies departments need to stock a range of goods, and must be kept informed by professional staff about what is required and what is obtainable.

Appendix 7

Guidelines for professional staff on urinary incontinence and faecal incontinence

Urinary incontinence

There are a number of different manifestations of abnormal bladder function, some of which result in incontinence. When this occurs, understanding of the type and form influences management. Answers to the following questions, put to the patient sympathetically and in private, will be a guide.

- 1 How long have you been troubled in this way?
- 2 Did it start suddenly or gradually?
Was it associated with any particular event?
- 3 Do you feel the need to pass urine more frequently than usual during the day? How often? And also at night? How often? Are you drinking more fluid than usual?
- 4 Do you have a feeling of urgency? How much warning time do you get?
Do you ever have an 'accident'? (Urge incontinence)
- 5 Do you wet yourself without being aware of passing urine? Is the leakage a little or a lot? (Retention with overflow incontinence; reflex emptying)
- 6 Do you have a small leakage of urine on slight exertion, such as coughing or sneezing or laughing, or even turning over in bed? (Stress incontinence)
Or is the leakage on exertion considerable? (Unstable bladder + stress incontinence)
- 7 Do you dribble just after having passed urine?

If necessary, the information obtained can be verified and expanded by talking separately, and out of hearing of the patient, to relatives and other members of staff.

The promotion of continence

Observation and charting of the pattern of micturition of the patient is necessary, over a week or longer, as well as a note of the pattern of micturition before admission. The patient at home can be asked to fill in a simple chart. (An example is shown on page 45.)

When the patient is incontinent but aware of the need to micturate, attention to environmental factors can help to re-establish and maintain continence. The following need to be looked at.

- 1 What does the pattern of micturition show, and is the existing toilet routine frequent enough for the patient's needs? Can the patient indicate these needs? (If aphasic this is especially important.) Stroke patients may also require visual retraining in relation to toilet facilities.
- 2 Are adequate toilet facilities, whether lavatory, commode or urinal, available and readily accessible? Relative heights of bed, chair and commode are important, as well as the type and positioning of the commode. Warmth and privacy are essential. Can clothing be managed quickly and easily?
- 3 If the patient is on diuretics, are they being administered at the most suitable time? Are they still necessary?
- 4 Is there a reasonable fluid intake during the day? Is there need to restrict drinks two or three hours before sleep?
- 5 Is night-time sedation impairing awareness of the need to micturate and so causing bed-wetting?
- 6 Is the patient constipated? Constipation leading to faecal impaction is a common cause of both urinary and faecal incontinence (spurious diarrhoea) in the elderly.

On the basis of information so far gathered, consideration can now also be given to the possibility of habit retraining where appropriate. This differs from rigid toileting.

Management of incontinence

Where certain forms of incontinence are not amenable to treatment (apart

Action on incontinence

from routine rigid toileting) personal protection is essential. The type of protection used will depend on:

- a the amount and occasion of leakage, whether during the day or night, and whether when up and dressed or in bed;
- b the age and physical and mental condition of the patient, and the degree of mobility and dexterity.

Pads and pants

There is a variety available, and choice depends on individual need. They are:

- a based on different principles;
- b of differing degrees of absorbency;
- c of different designs.

They are used mainly by women, but may be appropriate for some men. Supply should be through health authorities' supplies departments, although the range may be limited. Private supply (mainly by mail order) is an alternative.

Urinary appliances

These are available for men, but most types need to be chosen and fitted individually. Some hospitals provide a skilled fitting service, and certain large firms of medical suppliers can also fit and supply on prescription.

Long-term catheterisation (for intractable incontinence)

The use of a catheter (a joint medical/nursing/patient decision) may permit more independence, for instance, to live at home. Drainage into a leg-bag, or a bag supported and concealed in a waist-belt, enables the patient to lead a fairly active daily life.

Underpads

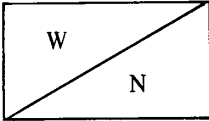
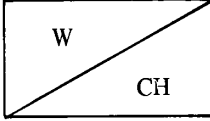
If these are used, are they of sufficient size and absorbency? Are they positioned correctly, that is, across the bed and not lengthwise?

Appendix 7

PATIENTS NAME:

WARD:

Week commencing:

CODE		Night Time							
WET = W DRY = D PASSED URINE = PU NOTHING = N		eg				CHANGED BED = CH			
DATE TIME	MON	TUE	WED	THU	FRI	SAT	SUN		
9.30									
11.30									
13.30									
15.30									
17.30									
19.30									
21.30									
23.30									
1.30									
3.30									
5.30									
7.30									

- 1 On approaching patient mark chart WET (W) or DRY (D) in top triangle every 2 hours.
- 2 Then toilet patient and mark lower triangle PASSED URINE (PU) or NOTHING (N).
- 3 At night time mark chart as in day but toilet patient at 10.00pm and 2.00am
At other times change if wet and mark chart CHANGED (CH) in lower triangle.

Action on incontinence

Laundry and supply/disposal services

For the patient at home, are these services provided, and are they adequate?

Faecal incontinence

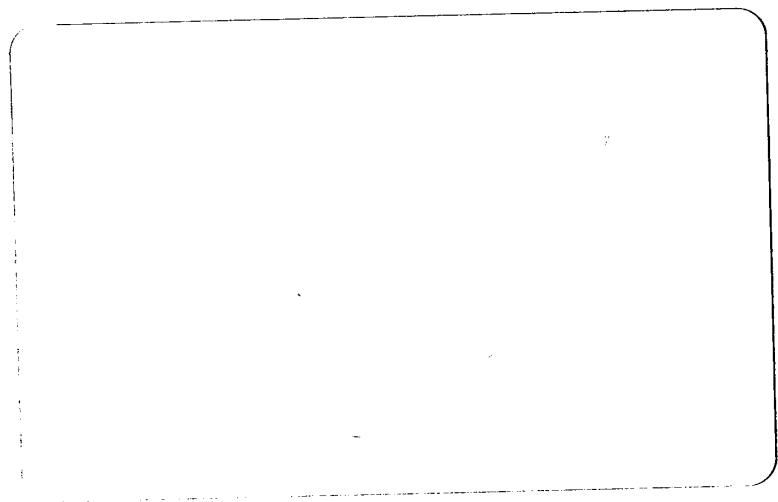
Checklist – management of bowels

Bowel activity or actions can be a source of worry to patients. In order to alleviate these worries and prevent distress and constipation, or worse still faecal incontinence, time spent with the patient on admission to find out normal habits is of value. The following points need to be considered.

- 1 How regular is the normal bowel habit?
This can vary from three times a day to three times a week.
A record is necessary of frequency, nature and number of stools and if there is pain or discomfort on defaecation.
- 2 When were the bowels last opened?
- 3 Is the bowel stimulated by any particular event, such as a glass of hot water first or last thing?
- 4 Is there a history of the use of laxatives? Are any constipating drugs being taken, such as analgesics, hypnotics, iron?
- 5 Should diet be considered? A new environment and sedentary existence, unaccustomed diet, limitation of fluid intake and so on, may affect bowel habits.
- 6 Are toilet facilities adequate in numbers, appropriate in type and readily accessible? Are there sufficient commodes for night and emergency use and are they of the right design?
- 7 If feasible, can a lavatory or commode be used instead of a bedpan? The latter is difficult to use and can lead to excess straining.
- 8 Whatever toilet facility is used, is it available at the time of need and can it be used with privacy? Lack of privacy is inhibiting and distressing. Are there locks on the lavatory doors?
- 9 How does the patient communicate need to defaecate, particularly if aphasic, unable to speak much English or extremely shy?

Appendix 7

- 10 Can patient wash hands or can wipes be provided?
- 11 If faecal incontinence exists is it due to faecal impaction? This is very common in elderly people. After disimpaction, minimal dosage of aperients should be used to restore regular emptying of the rectum. Type and dosage need to be supervised by the doctor. Also, thought needs to be given to the type of food acceptable to the patient and of sufficient fibre content, and the giving of adequate fluids.
- 12 Continued observation is required to note any change in bowel habit.



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