I called the incontinence hot line….they asked “can you hold please”

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Learning outcomes

• Discuss the ramifications of faecal incontinence in the elderly
• Recognise the impact of faecal incontinence on the patient’s wellbeing
• Describe normal bowel function and age related changes
• List the risk factors for faecal incontinence
• Identify the elements of assessment and management of faecal incontinence
• Interpret the nurse’s role in promoting continence in the elderly
Incontinence – is never normal

➢ Any accidental or involuntary loss of urine from the bladder (urinary incontinence) or bowel motion, faeces or wind from the bowel (faecal or bowel incontinence).

➢ It can range in severity from 'just a small leak' to complete loss of bladder or bowel control.

➢ It can be urinary incontinence or bowel incontinence. In older residents both can be present at the same time and is referred to as ‘doubly incontinent’.

➢ It’s often manageable and in some cases can be treated as well.

➢ Failure to adequately assess, treat and support those with incontinence can affect their dignity, social functioning, employment opportunities and lifestyle.
Continence is a complex mechanism

- Mentation – adequate cognitive function
- Mobility
- Manual dexterity
- Effective lower urinary tract functioning
- Motivation
- Environmental / iatrogenic barriers

Requirements of continence
Faecal incontinence

➢ Faecal incontinence is the involuntary loss of anal sphincter control that leads to unwanted release of liquid or solid faeces at an inappropriate time or in an inappropriate place.

➢ Classified as a type of bowel dysfunction.

➢ Prevalence increases with age.

➢ 17% in men and women over 60 years of age.

➢ 46% of residents in Residential Aged Care Facilities (RACF).

➢ Faecal incontinence is a risk factor for admission to RACF.

➢ Physical effects aren’t life threatening however symptoms have a devastating affect on the Quality of Life (QoL) of individuals, families and friends.
Impact of Faecal incontinence

➢ Psychological
• Decreased quality of life.
• Worry and coping.
• Depression.
• Nursing home placement.

➢ Medical consequences
• Falls and fractures.
• Skin infections /incontinence associated dermatitis.
• UTI’s

➢ Economical consequences
• $42.9 billion in 2010
How the bowels work?

➢ https://www.youtube.com/watch?v=6CoIDScaAzog

➢ Bowel function is controlled by rectal sensation, rectal accommodation, and anal sphincter muscles.

➢ The two anal sphincter muscles- an involuntary inner and a voluntary outer- hold the faeces in the rectum until a toilet can be reached, at which time they relax and release the stool.

➢ People who suffer from faecal incontinence may not sense a full rectum and, if so, may not be able to hold faeces because of damaged nerves and sphincter muscles.
Age related changes

➢ Thickened external anal sphincter.
➢ Thickened internal anal sphincter.
➢ Reduced rectal compliance.
➢ Reduced rectal sensation.
➢ Perineal laxity.

❖ Incontinence is a **geriatric syndrome**.
Risk factors of faecal incontinence

➢ Advancing age & impaired mobility.
➢ Depression.
➢ Visual deficits.
➢ Constipation & faecal impaction.
➢ Medical conditions which can cause higher central nervous system damage like cerebrovascular disease, dementia, autonomic neuropathy.
➢ Cognitive impairment.
➢ Anal sphincter or pelvic muscle weakness - from obstetric trauma or surgery.
➢ Diarrhoea related to medications (antibiotics/laxatives), infectious disease (C. Difficile) or other non-infectious causes (Lactose intolerance) increases the risk of incontinence.
➢ Carcinoma or rectal prolapse also often lead to faecal incontinence.
### What is the mechanism??

<table>
<thead>
<tr>
<th>1.</th>
<th>Dementia</th>
<th>➢ Impairs awareness of need to defecate, loss of inhibitory control until defecation is appropriate &amp; impaired mobility.</th>
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<tbody>
<tr>
<td>2.</td>
<td>Stroke /brain tumour</td>
<td>➢ Impaired awareness of rectal afferent input, slowed motor processing, communication barriers-aphasia / dysarthria, frontal lobe damage.</td>
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<td>3.</td>
<td>Multiple sclerosis</td>
<td>➢ Decreased external anal sphincter pressures, decreased volumes of rectal distention to inhibit the internal anal sphincter.</td>
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<tr>
<td>4.</td>
<td>Diabetes mellitus &amp; neuropathy</td>
<td>➢ Neuropathy of both sensory and motor nerves, internal anal sphincter dysfunction, loss of sensation.</td>
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<td>5.</td>
<td>Faecal impaction</td>
<td>➢ Altered rectal sensation</td>
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Constipation

Stool sitting in the rectum for a long time

Water getting absorbed from the old stools sitting in rectum and stools becoming harder and harder to make a plug

Prolonged and repeated distended rectum causing nerve damage and reduced sensation or reduced sphincter control

Faecal incontinence

Faecal impaction & water sweeping through sides

Overflow diarrhoea
Faecal incontinence assessment

➢ Medical history & medications.
➢ Type of diet.
➢ Frequency, type of incontinence (solid, liquid or gas) & amount.
➢ Continence assessment form on admission or if condition changes.
➢ Any continence aids used.
➢ Bowel chart and other symptoms like constipation, pain or straining.
➢ Patient assessment in relation to mobility, dexterity, cognitive, visual deficit etc.
➢ Physical examination & investigations may be required in some types of incontinence. Rectal examination may be carried out to rule out faecal impaction, prostate enlargement or rectal mass and to assess anal sphincter tone (resting and squeeze pressure), rectal prolapse and pelvic muscle tone.
Incontinence screening “DRIP”

- Delirium, depression
- restricted mobility/ restricted environment
- Infection, inflammation, impaction
- Pharmaceuticals, pain
Functional incontinence

➢ Incontinence related to physical or psychological impairment. For e.g., reduced mobility or pain might be interfering with getting to the toilet on time, arthritis affecting ability to manage the clothes, ability to sequence the task.

➢ In residents with dementia inability to dress/transfer can increase the incidents of faecal incontinence. However these incidents can be significantly reduced by individualised scheduled toileting program.
Environmental incontinence

➢ It’s often the environmental factors which contribute to urinary incontinence. For e.g., long corridors, poorly marked bathroom doors, attitude of caregivers, call bells not in reach, cleanliness etc.

➢ Case Scenario – John is 80 years old gentleman admitted to your unit with background history of mild dementia, diabetes mellitus and ischaemic heart disease. Since John had come over he has been moving his bowels in the pot plants or dustbins or sometimes wandering into other people’s room to use the bathrooms. What was puzzling is that he passed by four bathrooms in the corridor that were designated for the residents.

➢ This is the bathroom sign in the corridor:
After investigation it was found that bathroom doors were always closed due to fire regulations.

The sign is not appropriate to start with.

Also signs were actually at the top of the door.

Recommendations –

• Especially for people with cognitive impairment, universal signs are not appropriate.

• Signs should be at eye level or below not at the top.

• Toilet seat should be visible and lid should not be closed.

• Timed toileting (e.g., 30 minutes after breakfast).
Management

➢ Treatment depends on the underlying cause.

➢ If impaction is the cause of faecal incontinence: - Disimpaction by

❖ Oral therapy –
• Movicol is the treatment of choice for disimpaction.
• Up to 8 sachets daily, dissolved in 1 L of water and consumed within 6 hours.
• The maximum length of therapy for the impaction regimen is usually 3 days.

❖ Rectal therapies –
• Fleet Ready-to-Use enema (Sodium phosphate).
• For constipation or impaction: 133 mL as a single dose, gently inserted into the rectum.

❖ Manual disimpaction - last resort
• Should be performed under general anaesthetic.

Refer to IMPACT guidelines.
Management

➢ If diarrhoea is the cause – management would be directed towards treating it. If it’s related to infectious disease then management will be different however if it’s not infectious, medications can be used to stop diarrhoea and reduce the symptoms of faecal incontinence.

➢ Increased fluid and fibre intake to improve stool volume and consistency.

➢ Pelvic floor muscle retraining.

➢ Timed toileting.

➢ Maintain / promote mobility.

➢ Proper shoes & appropriate assistive devices.

➢ Uncluttered walkways.

➢ Assist as required.

➢ Continence aids
In addition to all of above mentioned strategies, additional responsibilities include:

- Conduct continence assessment, use of any continence aids & develop bowel management plan depending upon patient’s specific needs.
- Commence a toileting regime for e.g., sitting on toilet 30 minutes after breakfast (it will depend upon the person’s usual pattern).
- Assist with toileting process if required.
- If patient can be mobilised (even on night shift) encourage to use the toilet rather then a bed pan. This ensures adequate bowel emptying.
- Ensure call bell is handy and environment is clutter free.
- Ensure optimal nutrition & fluid intake.
- Toileting should be private and comfortable.
- A raised toilet seat may be required to feel comfortable and safe.
Position is important

➢ Advise the person not to strain down while attempting to defecate.

➢ A knees-above-hips position places the pelvic floor muscles in the correct position to assist defaecation. If required use a foot stool.

➢ If the person is given an enema / suppository it’s essential to sit them on toilet to allow full evacuation. If patient is immobile use the appropriate equipment for transfer. If person doesn't have full sitting balance liaise with occupational therapist for appropriate equipment to assist sitting on toilet.

➢ Time management/workload issues should be no excuse for not sitting patients on toilet.
THANK YOU for LISTENING ANY QUESTIONS?