

# Perceptions and barriers that influence the ability to provide appropriate incontinence care in nursing home residents: Statements from nursing staff

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## ABSTRACT

Urinary incontinence is a common medical condition among nursing home residents. Urinary incontinence in older people has a multifactorial etiology and is therefore more difficult to assess and treat than urinary incontinence in younger people. Previous research has shown that incontinence care in nursing home residents often is inadequate and little systematized. The aim of this study was to identify perceptions and barriers that influence the ability of the nursing staff to provide appropriate incontinence care. This was a qualitative study using focus-group methodology. Data were collected from three focus-group interviews with 15 members of the nursing staff from six different units in a nursing home. The focus-group interviews were recorded on tape, transcribed verbatim and analyzed according to qualitative content analysis. Three topics and eight categories were identified. The first topic, *Perceptions and barriers associated with residents*, consisted of one category: “physical and cognitive problems”. The second topic, *Perceptions and barriers associated with nursing staff*, consisted of three categories: “lack of knowledge”, “attitudes and beliefs” and “lack of accessibility”. The third topic, *Perceptions and barriers associated with organizational culture*, consisted of four categories: “rigid routines”, “lack of resource”, “lack of documentation” and “lack of leadership”. The findings from this study show that there are many barriers that might influence the possibilities of nursing staff to provide appropriate incontinence care to residents in nursing homes. However, it can neverthe-

less seem like opinions and the attitude of nursing staff, together with a lack of knowledge about UI, are the most important barriers to provide appropriate incontinence care.

**Keywords:** Content Analysis; Focus Groups; Incontinence Care; Nursing Homes; Urinary Incontinence

## 1. INTRODUCTION

Urinary incontinence (UI) is one of the most common medical conditions among nursing home residents. Between 45% and 70% of residents in nursing homes have UI and the prevalence increases progressively with age [1]. UI is associated with significant morbidity and utilization of health care resources [2]. Furthermore, UI has a significant impact on resident’ psychosocial well-being and quality of life [3]. UI among nursing home residents has a multifactorial etiology, involving neurologic disorders, urologic and gynecologic conditions, behavioral and psychological factors, and functional impairment. These conditions may have an effect on bladder control and cause urinary frequency, urgency, urge incontinence or problems with bladder emptying. Nursing home residents are getting older and therefore, on average, require more assistance with daily activities, including going to the toilet [4]. Cerebral changes can cause psychological, behavioral and environmental problems and contribute to the inability to use the toilet or to ask for assistance [5]. Although UI has a multifactorial etiology in the older population, research has shown that many of the contributors to UI are reversible with appropriate intervention. Studies have reported that up to 70% of the

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older population suffering from UI can be cured or ameliorated with lifestyle adjustments and behavioral therapies [6-8]. UI among frail nursing homes residents is often more complex to assess and to treat than UI in younger people. It is therefore important that the nursing staff performs a careful assessment of incontinent residents in order to be able to give appropriate care. The complexity of UI in frail nursing home residents has been described as a challenge for nursing staff. Several studies have reported that incontinence care is incomplete and little person-centered [9-11]. Incontinence care is a very sensitive matter, and it is important to preserve a resident's privacy and dignity during such care. In a qualitative study, six elderly women with UI in long-term care were interviewed about their experiences of living with UI in long-term care. The women told that they lacked decision-making and choices about their personal UI care. Further, they described how loss of control of bodily functions, loss of dignity and loss of independence influence their quality of life and self-esteem [12]. Resnick and colleagues performed a qualitative study in a nursing home. They found that the attitude of nursing staff was a major contributor to UI. Lack of knowledge about UI and negative attitude towards effectiveness of UI treatment among nursing staff, together with adhering to toileting schedules or ignoring requests for toileting, were mentioned by directors of nursing homes as reasons for inadequate UI care [13]. Continence assessment by nursing staff has traditionally focussed on selecting the appropriate absorbent pads, rather than on treatment of incontinence [14,15]. Several countries have developed evidence-based guidelines for the prevention and treatment of UI [16-18]. Despite an increased focus on UI among residents in nursing homes, researchers still report problems with the implementation of appropriate incontinence care [19]. The nursing staff plays a primary role in incontinence care. However, little research has been performed on nursing staff's experience with incontinence care.

### Aim

To identify perceptions and barriers that influence the ability of the nursing staff to provide appropriate incontinence care.

## 2. DESIGN AND METHOD

This article is based on a qualitative study that uses purposive sampling and a focus group methodology. The idea behind a nursing focus group is that the group process will help the participants to express their experiences in a way that would be more difficult in a one-to-one interview situation [20]. According to Kitzinger, focus groups are particularly useful to study attitudes and

experiences, and to study how knowledge and ideas develop and operate within a cultural context [21].

### 2.1. Participants and Setting

The study was carried out at six different units in one Norwegian nursing home. Eighteen nurses were invited to participate, including six Charge nurses (CN), six Registered nurses (RN) and six Certified Nursing Assistants (CNA). All nurses and nursing assistants gave informed consent prior to their participation to the study. The median work experience was respectively 12 years for CN, 9 years for RN and 23 years for CAN (**Table 1**). RN and CNA were chosen according to the time schedule; meaning that only nurses that were at work during the days of the interviews were asked. Of those who agreed to participate, a random sample was chosen. Three participants that had agreed to participate did not show up for the interviews; two were unable to come for medical reasons and one had forgotten the appointment. In all, 15 nurses participated; 14 females and one male. The nurses were divided in three groups according to their profession. Each group consisted of 5 participants. According to Kitzinger, and Polit *et al.*, the ideal group size for focus interviews is four to eight participants [21,22]. We choose to form groups according to profession based on the assumption that the participants would feel more comfortable and free to express their experience within their own professional group. None of the nurses in the respective groups worked together in the same unit. Participation was based on informed consent. Permission to perform the study was granted by the Local Ethics Committee at Mid-Sweden University.

### 2.2. Focus-Group Interviews

Data from focus group interviews was collected during March and April 2010. Two moderators were present. The first moderator led the interviews, encouraged open conversation and tried to involve all participants. The second moderator took notes, observed reactions of the participants, and provided an oral summary halfway and at the end of the focus group interviews. The participants were invited to add or correct the summaries. Once confirmation was obtained, these summaries became part of the data analysis. A focus group guide was developed

**Table 1.** Characteristics of the interviewed nurses.

Qualification	Gender	Number	Years of experience
Charge nurses	M	1	6
	F	4	12, 12, 14, 30
Registered nurses	F	5	1, 9, 9, 13, 32
Certified nursing assistants	F	5	6, 22, 23, 34, 37

based on the overall research question. Nurses were asked to reflect on their practice concerning continence care and to discuss what knowledge they thought was necessary to handle residents' different bladder disorders. They were also asked to explain which measures and treatment residents with these problems received. One of the main aims was to identify factors that might influence the ability of the nursing staff to perform appropriate incontinence care. In addition, the participants were asked how they made sure that the residents received appropriate incontinence care. Members of the nursing staff participated in the focus groups during their regular work hours and at the nursing home facility. The interviews lasted between 70 and 90 minutes and were tape-recorded and transcribed verbatim by the first author (LHS). The transcriptions were analyzed and interpreted using qualitative content analysis.

### 2.3. Content Analysis

Content analysis has been defined as "the process of identifying and categorizing the primary patterns in data" [23]. According to Patton [23], Baxter [24] and Krippendorff [25] content analysis is appropriate for analyzing text from interviews. Interpretive content analysis in this study has been carried out in the following way: the interviews were read thoroughly several times in order to get an overall picture of the contexts. Topics identified were used to organize the content in a meaningful way. Meaning units created by one or more sentences related to the different topics, were identified and condensed to shorter formulations. Subcategories were formulated for subsequent abstraction into categories (**Table 2**). Finally, an interpretation of the whole was made [23]. The first author (LHS) analyzed the text. After that, the analysis was evaluated by a second (OH) and a third author (EK) in order to address the question of trustworthiness and discuss possible interpretations until consensus was reached [23].

## 3. FINDINGS

In each of the three groups, nurses expressed that there were barriers that influenced the ability to provide appropriate incontinence care. These barriers were associated with three specific topics *i.e.*, residents, nursing staff and organizational culture. The focus interviews revealed differences in involvement with incontinence care among groups. The CN were rarely involved in the management of UI. Some of the RN explained that a high workload made them prioritize other tasks in the units. They thought the high workload was an important barrier to provide good UI care. The CNA were the ones who were most often responsible for incontinence care in practice. Despite the fact that they revealed a lack of knowledge

on how to improve UI, they showed great interest for the residents' problems. All of them had worked within nursing homes for several years and had obtained a lot of experience with incontinence care. They were able to refer to many examples from clinical practice and were often focused on pads; particular pads-shifts, but also type of pads. Below, the perceptions and barriers and their corresponding categories are described.

### 3.1. Perceptions and Barriers Associated with Residents

*Physical and cognitive problems.* The RN described the residents' physical and cognitive problems as an important barrier preventing appropriate incontinence care. Most of the residents in nursing homes have several diseases and use different types of medication that can affect the bladder function. A number of residents were not mobile and were dependent on lifts to get out of their beds and wheelchairs to reach the toilet. These toilet visits were often demanding, in the sense that it took a lot of time and effort from the staff. The result was often that residents couldn't visit the toilet as often as they wanted. Instead of toilet visits, residents wore absorbent pads. Many of the residents were cognitively impaired. This could create problems with finding the toilet and expressing the need to come to the toilet. Some residents could get angry, refusing both toilet visits and pad changes. Nurses expressed sympathy with the problems of the residents.

*"It must be frustrating, not knowing where the toilet is and not being able to ask for help. Some of the residents react with anger when they cannot find the toilet. We have experienced residents urinating in the garbage can or in other appropriate places. But luckily we know our residents well. It is often a pattern; they get uneasy and show it by walking up and down the corridors"*.

The CNA described anger and aggression as being a big problem for some of the cognitively impaired residents. They had to develop creative methods to persuade the residents to visit the toilet. Some needed a lot of time before they would go. As a result, pads were often an easier alternative.

### 3.2. Perceptions and Barriers Associated with Nursing Staff

*Lack of knowledge.* Most of the nurses had worked in a nursing home for many years. However, few had upgraded their basic knowledge on UI after graduation. All groups agreed that their basic knowledge on UI was insufficient. A RN put it like this:

*"If we knew something about the causes, we would be able to do something about it. Maybe nurses would then*

**Table 2.** Analysis of content, some examples.

Meaning units	Condensed meaning units	Sub-categories	Main-categories
<i>If we knew something about causes and treatment strategy; we can do something with the problem. Nursing staff wanted more accurate procedures and guidelines to manage UI.</i>	Important to know causes and treatment. Procedures and guidelines unknown.	Causes Treatment Guidelines Procedures	Lack of knowledge
Nursing staff is busy with other tasks in unit or having more than one resident to go to toilet at same time. Nurses referred to situations where they were busy with bathing, dressing, feeding.	Busy with other tasks when resident needs assistance to go to toilet.	Dressing Bathing Feeding More than one resident	Lack of accessibility
Nursing staff paid little attention to improve or prevent UI in residents. A common belief among them was that UI is a completely normal consequence of aging and that treatment had little or no effect.	UI is a normal consequence of aging. Little attention to improve and prevent UI. Treatment had little or no effect.	Age Attention Treatment	Attitudes and beliefs

*understand why some residents need more time on the toilet than others”.*

The RN and CNA expressed a lack of knowledge with regard to assessment and management of UI. They wanted more accurate procedures and guidance in this area. Evidence-based clinical practice guidelines to manage UI in older people were unknown among all groups. Some of them, at the same time, expressed a lack of confidence in the treatment and doubted whether or not it would improve the continence status for the residents' with UI.

*Attitudes and beliefs.* The interviews revealed that nurses paid little attention to improve or prevent UI in residents. A common belief among them was that UI is a completely normal consequence of aging and that treatment had little or no effect. Most of the nurses expressed that urinary incontinence after all is common.

*“There are so many that have it, and so we think that’s the way it is. We don’t reflect upon it. We react first and foremost when problems occurs”.*

With problems she meant urinary retention and urinary tract infections.

*Lack of accessibility.* The CNA believed that lack of personnel and need to prioritize other tasks meant that the resident didn’t get the help they needed to reach the toilet in time. They thought this was an important factor in the residents’ incontinence problems. Nurses also referred to situations where they were busy with bathing, dressing, feeding or exchange of reports during shifts.

*“We have to prioritize. We think it is more important that they eat well than that they visit the toilet in time. We always have too few resources. It is not so important compared to other things, such as food, drinks and medication”.*

### 3.3. Perceptions and Barriers Associated with Organizational Culture

*Rigid routines.* At admission to the nursing home, the

resident’s continence status was documented in the medical record by the physician. Further assessment was rarely carried out. Nurses said they assumed that the residents who were incontinent when they moved to a nursing home were previously assessed.

*“No, incontinence is not discussed with a doctor when they come in with this diagnosis. We discuss it when the situation changes or there are problems, or when they become incontinent after they have moved here. But there are not many in this nursing home that were not incontinent when they moved in”.*

It was very rare that residents were sent to a specialist for assessment of their incontinence problems. The few times this did happen, it was mostly to exclude physical causes in the residents that asked for frequent visits to the toilet. In residents who were not able to get to the toilet on their own or ask for help, it was common that toilet visits were initiated by the nursing staff and the routines in the nursing home. The nurses toileted residents when they woke up in the morning, before and after meals and at bedtime. Usually residents visited the toilet three to four times daily. Help with nightly visits was rare. Prompted voiding or other behavioral programs were unknown for all nurses. Interventions in residents with UI were mainly focused on type of incontinence products used. Every unit had their own nurse who had the responsibility to ensure that the residents got the right type of absorbent pad and the right size related to the leakage volume. This nurse also made sure that pads were available. This “pads contact” was one of the nurses working regularly. The contact was allowed to attend yearly seminars arranged by different vendors. Several of the nurses admitted that incontinence care rarely was individually adapted.

*“It is not always our own choice, but we do not have enough nurses, so it is easier to follow the routines in the unit. However, we have experienced that if we take residents who are incontinent to the toilet more frequently, they have actually remained dry longer”.*

*Lack of resources.* The lack of time and number of nurses were mentioned as important cause for inadequate incontinence care.

*“Sometimes the workload is so high that we cannot provide the best care. It can happen that a resident needs two nurses to be able to come to the toilet. When there is only one nurse available at that moment, this can be a problem. It can also happen that we are inside a room and they cannot find us”.*

The nurses realized that the help the resident got was deficient and not individually adjusted. They thought individually adjusted help could be provided if there were more resources available. The CN, on the other hand, meant that hiring of unskilled nursing staff for shorter periods was the main problem. New faces meant more people that didn't know the routines, the rules and/or the residents. The CNA were frustrated because of restrictions imposed by the management on how often they should change pads and what type of pads they should apply to residents. They thought these decisions had an impact on the residents' comfort and quality of life.

*Lack of documentation.* None of the units had procedures for residents with different bladder disorders, neither for preventing, examination or treatment. Some of the units had care plans, but most were outdated and not very detailed. Documentation of residents' incontinence problems was rare and the care plans were seldom applied in daily routine.

*Lack of leadership.* The CN had only a small role in the management of UI. They said that they trusted nursing staff to take care of residents' incontinence problems in a sufficient way. On the other hand, both RN and CNA expressed the need for seminars to refresh their knowledge about UI. They also wanted more focus on this area from the management. They expressed that they wanted more time for reflection and debates about incontinence problems in the units. The CN had a weekly meeting with the nursing staff in which different problems were discussed, but bladder disorders were seldom a topic at these meetings.

#### 4. DISCUSSION

This study identified perceptions and barriers that influence the ability of nursing staff to provide appropriate incontinence care in nursing home. These barriers were associated with three specific topics, *i.e.* residents, nursing staff and organization culture. In the topics, the following categories were highlighted: physical and cognitive problems, lack of knowledge, attitudes and beliefs, lack of accessibility, rigid routines, lack of resources, lack of documentation and weak leadership.

Impaired mobility and cognitive impairment have been

consistently identified as risk factors for UI in the elderly population [1,26,27]. Our study reported that toilet visits often were demanding, in the sense that it took a lot of time and required a lot of resources. Jirovec (1991) found that training and competency in transfer techniques may improve nursing staff's capacity to implement a toileting regime [28]. Although cognitive impairment is a risk factor for developing UI, research has shown that not all patients with dementia are incontinent. It usually emerges at the stage of moderate dementia [29]. Previous studies have shown that cognitive impairment should not exclude nursing home residents from incontinence assessment and treatment, especially behavioral therapies [26]. Prompted voiding has been shown to be effective in cognitively impaired nursing home residents [26]. Timed voiding has been described to be appropriate for residents who cannot independently toilet themselves [30].

In accordance with the current study, several studies have reported that incontinence care is inadequate and that the nursing staff has a lack of knowledge about UI [9,10,31]. Evidence-based clinical practice guidelines for UI in older people were unknown among all groups in our study. These guidelines address the major evaluative, diagnostic, treatment, and management issues of UI [16-18,32]. The nurses expressed that UI got little attention compared with other tasks, and they looked at the UI is a normal part of ageing and nothing can be done to prevent or treat it. A number of studies have shown that nurses' attitudes and values determine how they think, interact and behave towards older people [33,34]. Negative attitudes can lead to ageism which is a process of stereotyping and discriminating against someone because they are ageing or aged [35]. According to Henderson *et al.*, treatment options with regard to UI depend on attitudes and beliefs among the nursing staff [36]. Wyman, outlines that educational and attitudinal barriers, in addition to organizational, financial and professional barriers, are important for implementation of evidence based incontinence care [37].

According to Smith, the organizational culture has a major impact on continence care [38]. Organizational culture is described as a pattern of shared values, knowledge and assessments that people within an organization learn as a group, pass on to new members, and which influence their social interactions [39]. Eide *et al.* describe the culture as “something that sits in the walls”, a pattern of action. The culture can consist of ritual behavior, common rules and beliefs about what works well, and therefore, be regarded as true. Attitudes are taken for granted and they will reign. If habits, beliefs and practice patterns have been repeated over a long time, it will be difficult to develop other ways to solve problems [40].

The incontinence care in the current study was char-

acterized by routines toileting and changing of pads. Campbell and colleagues found that the sociocultural environment of nursing homes fosters routine care, which tends to impede nursing staff behavior change [40]. Neither prompted voiding, nor other behavioral intervention programs were used in the units. Several studies have suggested that person-centered incontinence care might be able to significantly reduce the rate of UI among nursing home residents [41,42]. Person-centred care has been defined as treating people as individuals and enabling them to make choices about their care [43]. A holistic assessment is essential to identify resident needs, which may require specific interventions in order to ensure that dignity and integrity is maintained and person-centred care is achieved [43]. Older people with UI often feel a loss of dignity in care settings because individual needs can easily be forgotten when it comes to the practicalities of toileting and incontinence care [42].

As long as the resident in our study did not ask to come to a specialist for assessment and treatment for their UI, they were rarely sent there. Previous studies have reported that less than 5% of older incontinent people have been evaluated by specialist [44]. Furthermore, only 1% to 2% of women in nursing homes have an official diagnosis of UI [44]. According to Minichiello *et al.* are health professionals a major source of ageist treatment. Ageism in health care can relate to receiving a lower standard of service or even to being denied access to the service [45].

In this study, unskilled staffs together with high workload were identified as important barriers that have to be overcome in order to be able to provide appropriate UI care. A frequently cited barrier to implementation of toileting programs in nursing homes are the current staff-to-residents ratios in most facilities [37,46]. According to Anger *et al.*, more than 50% of females in nursing homes need assistance to use the toilet [45]. Schnelle *et al.*, found that residents who needed assistance with toileting, reported that they preferred an average of 2.4 toileting assists per day and that they received an average of 1.7 [9].

Good documentation can ensure the continuity and quality of care that nursing home residents receive. In addition, documentation is a tool for the transfer of knowledge between nurses. Difficulties in defining types of UI and a lack of validated continence assessment tools for older people contribute to poor documentation and treatment plans [9]. The interviews revealed inadequate documentation in all units. According to Mueller *et al.*, Manghall *et al.* and Saxer *et al.*, documentation regarding incontinence care is often inadequate in nursing homes, and poor documentation is linked to inadequate knowledge [47-49]. McElroy *et al.* found that poor documentation occurred in all areas of health care in nursing

homes. However, many nurses did not see the link between good care and documentation [50].

Our findings showed that the CN were rarely involved in the management of UI and the RN attention was directed to other tasks in the units. In accordance with other studies, CNA showed the greatest involvement with regards to incontinence problems [51]. According to Smith, RN have no peer group, are frequently overwhelmed by regulations and residents needs, and have a lack of reinforcement from superiors [38]. In the absence of RN, CNA have had to take the main responsibility of incontinence care and have therefore been described as the most powerful group within nursing homes [38]. Studies have shown that medical directors did not view UI as a medical problem and lack of medical directors input has been a barrier to improve incontinence care [19]. Wyman identified limited nurse leadership in the field of incontinence as it is not seen as a priority with the competing demands on nursing [37]. Wright *et al.*, found that leadership, culture and evaluation were weak and not conducive to person centered continence care and management in rehabilitation units for older people [52]. However, active involvement by all members of the nursing staff, as well as support by managers and administrators, has been described as a crucial element to improve incontinence care among nursing home residents [47,53,54].

### Limitations of the Study

This study used purposive sampling and was limited to a small number of nurses from a single nursing home. This fact must be taken into account when interpreting the results. However, the purpose of qualitative research is not to generalize the results, but to transform and apply them to similar situations in other new contexts [22]. Nevertheless, our literature review from a number of countries inside and outside Europe confirms that these problems to provide appropriate incontinence care are known in other countries.

### 5. CONCLUSION

The findings from this study show that there are many barriers that might influence the possibilities of nursing staff to provide appropriate incontinence care to residents in nursing homes. Managers and administrators have a strategic role and responsibility for the way incontinence care in nursing homes is delivered, since key decisions will be taken at this level, and have a direct impact on the care provided. However, it can nevertheless seem like opinions, beliefs and the attitudes of nursing staff, together with a lack of knowledge about UI, are the most important barriers to provide appropriate incontinence care.

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