TOILETING
The purpose of this section is to help the learner acquire an understanding of problems in elimination that may occur later in life due to age-related changes, emotional stresses and chronic disease.

- Assessment
- Care plan
- Incontinence
- Toileting schedule
OBJECTIVES

The learner will be able to:

- Describe problems that may occur with elimination (bowel and urine) due to age-related changes, emotional stresses and chronic disease;
- Understand possible causes of bowel and/or urine incontinence;
- Describe possible interventions for bowel or urinary incontinence;
- Develop a care plan to address bowel and/or urine incontinence.
INTRODUCTION

- Problems in elimination may occur in later life due to age-related changes; emotional stresses or chronic disease.

- The physical and emotional cost of bowel and bladder control problems includes:
  - Increased risk of skin breakdown and infections;
  - Feelings of anxiety, shame, embarrassment, self-reproach and frustration;
INTRODUCTION CONTINUED

- Worry about the future;
- Threatened image as an adult;
- Loss of privacy to perform toileting functions;
- Social isolation.

Your responsibility is to help residents maintain normal function or be able to compensate for, or regain, lost function:
- You are also responsible for doing these tasks in a professional manner that preserves the person’s dignity.
The following discussion provides an overview of common age-related bowel and bladder problems, and approaches to assessment and management.

Slower action of the large bowel:
- It takes longer for waste materials to pass;
- This increases the risk of constipation.
**AGE-RELATED CHANGES**

- **Reduced sensation:**
  - The elderly are less able to tell the difference between gas, liquid or solids in the rectum.

- **Reduced strength and tone of the anal sphincter:**
  - Increases the risk of incontinence.

- **Individual patterns of elimination vary from daily to twice weekly:**
  - Knowing each resident’s normal bowel habits can help you recognize problems in bowel elimination.
CONSTIPATION

Constipation is the difficult passage of dry, hard stool. Other factors contribute to constipation are:

- Inadequate consumption of dietary fiber and fluids;
- Extended immobility due to painful arthritis, illness or injuries;
- Inhibited urge to defecate due to lack of privacy, unnatural positioning or discomfort, especially when using a bedpan;
- Some medications such as antacids and pain medications.
When you assess a resident’s bowel function, ask about diet, exercise, medications and laxative use. Be alert for the following:

- Passing hard-formed stool;
- Straining while trying to pass stool;
- Inability to pass stool;
- Decreased frequency from the resident’s normal pattern;
- Complaints about pressure and fullness in the rectum;
- Abdominal and/or back pain.
SIGN OF CONSTIPATION CONTINUED

- Signs of constipation resemble symptoms commonly associated with illness:
  - Confusion;
  - Diarrhea (due to fecal impaction);
  - Headache;
  - Indigestion and gas;
  - Listlessness;
  - Poor appetite.
Use of laxatives:

- Worry about constipation often leads people to seek the aid of laxatives. Dependence on laxatives or enemas damages the lining and function of the bowel and depletes the body of fluids and salts. If bulk-forming laxatives are taken without enough fluids, the esophagus or large bowel may become obstructed.

- Discourage the use of laxatives and enemas. They should be used only under the supervision of the resident’s health care practitioner.
Help residents maintain normal bowel movement naturally:

- Encourage fluids. Six to eight glasses of water a day is recommended. Drinking warm liquids such as lemon water when the resident wakes up in the morning and with breakfast starts bowel activity.

- Provide high fiber foods. Whole grains, bran cereals, raw fruits and vegetables, fresh fruit and nuts are good sources of dietary fiber. Grind or grate these foods if chewing or swallowing is difficult.
Encourage exercise such as walking, stimulates bowel activity:
- Any increased movement can help even if a resident is unable to walk.

Teach residents positions that may help move bowels. Sitting on the toilet in a squatting position, with feet flat on floor or stool and upper body leaning forward, or on commode with knees drawn up, helps the muscles move the bowels.
Fecal impaction is a severe form of constipation and can be life-threatening. It can lead to damage of the large intestine, and fecal and urinary incontinence:

- It involves a mass of dehydrated stool lodged in the colon or rectum;
- A diarrhea-like condition occurs when soft stool oozes around the fecal obstruction;
- If you believe a resident has a fecal impaction, immediately contact the person’s health care practitioner.
DIARRHEA

- Diarrhea causes serious health problems, including dehydration and skin breakdown;
  - Seek advice from a health care professional as soon as you know a resident has diarrhea;
  - Diarrhea may be a sign of serious illness, drug side effect or fecal impaction:
    - For that reason, never give a resident drugs used to relieve diarrhea unless the resident’s health care practitioner has instructed you to give medication.
  - Offer the resident extra fluids to prevent dehydration.
Fecal incontinence is an involuntary bowel movement:
- Fecal impaction, diarrhea and some medical disorders may underlie incontinence;
- Depression, stroke and other neurological problems may interfere with messages about the urge to defecate or the ability to wait.

Residents with fecal incontinence should establish a toileting schedule:
- Providing adaptive equipment and promote privacy;
- Provide a system for getting help if needed, such as a call bell, can help residents maintain control.
URINARY ELIMINATION

- Bladder problems are often due to age-related changes in the urinary tract:
  - By age 65 bladder capacity is reduced to one cup of urine compared to over two cups at age 25;
  - Weakened bladder sphincter muscle makes it harder to delay urinating until the bathroom is reached;
  - Decreased bladder muscle tone reduces the ability of the person to completely empty the bladder:
    - Residual urine increases the risk of bladder infections and incontinence.
Nerve signals to the brain that the bladder is full are slowed, giving less time to reach the bathroom;

Chronic illness or injuries can create bladder problems:

- Cognitive impairment can affect a person’s ability to find the toilet and remember proper toileting procedures;
- Depression, stress and fatigue can reduce motivation and ability to remain continent;
- Physical changes due to childbearing (in women) and fecal impaction increase bladder control problems;
Bladder infections can increase urinary incontinence;
Medications that increase urine output or sedatives reduce awareness for the need to urinate;
Alcohol increases urine output and reduces awareness of the need to urinate.

Urinary incontinence is the involuntary leakage of urine, regardless of the amount. The three major types are:
- Stress incontinence:
Leakage of urine during exercise, coughing, sneezing or laughing.

Urge incontinence:
- Inability to hold urine until the toilet is reached. It commonly occurs with conditions such as stroke, memory loss and Parkinson’s disease;
- Persons who have normal control are not considered incontinent if a crippling disorder keeps them from reaching the toilet before urinating.

Overflow incontinence:
- Leakage of small amounts of urine from a constantly full bladder. This commonly occurs in men who have enlarged prostate glands and people who have diabetes.
Paradoxical incontinence:

- Occasionally, just after an unsuccessful trip to the bathroom, an older person may have an accident while sitting in a chair;
- Some professionals believe it is caused by a mix-up in the conditioned reflex. In the bathroom, the “go” messages (the toilet and pressure on the buttocks) are confused with “don’t go”. As a result, the person does not respond to the need to eliminate while on the toilet;
- The resident may be helped by following a schedule, providing privacy and training in positioning and relaxation.
Inappropriate behavior sometimes accounts for incontinence:

- A resident may intentionally wet or soil themselves to get attention or to express anger;
- Treat the situation as you would any inappropriate behavior; do not draw attention to it. Avoid remarks or actions that might reinforce or reward the behavior;
- Establish a toileting schedule to reinforce the importance you place on continence;
- Assess what led up to the behavior to determine what other action to take.
- Consult the care team for ideas and support. Remember, you are trying to stop the behavior by not reinforcing it. Punishment of any kind is not appropriate.
MANAGING INCONTINENCE

- Careful evaluation, treatment and scheduled trips to the bathroom help many incontinent elderly people regain controls. Medications or surgery help some forms of incontinence. Steps for developing a management program:
  - Step one - Assessment:
    - Look for possible causes. Review past as well as current medical history for existing conditions known to contribute to incontinence. Consider environment and surrounding events; look for patterns;
Contributors to incontinence:
- Bladder infection – symptoms are frequent urination and burning sensation when urinating;
- Effect of medications;
- Bathroom too far to reach in time;
- Clothing too difficult to remove;
- Insufficient fiber or fluids in the diet.

Monitor bowel and bladder patterns:
- Note time, conditions and amounts related to elimination;
- Note differences in circumstances when the person is successful and unsuccessful in controlling elimination. For example, how did you respond to the person? Did you reward successful efforts?
Consult the care team about behavioral interventions and scheduling strategies. Seek medical care when:

- Sudden change in bowel or bladder habits;
- Sudden change in any behavior that may indicate a urinary tract infection;
- Sudden onset of incontinence;
- Urine is foul or sweet smelling;
- Urine is dark or cloudy;
- Urge is great but no output;
- Pain or burning upon urination;
- Diarrhea occurs;
- Stool is black, blood-tinged or looks like tar.
Step two - Develop a care plan.

- Establish toileting schedule based on assessment information;
- Schedule trips to the bathroom 10 to 15 minutes before incontinence typically has occurred. Normally, the bladder fills in two hours or more often if large amounts of fluid or caffeine is consumed.
- Identify care you need to provide:
  - If access to the bathroom is a contributing factor, list steps you need to take to correct the situation such as putting a sign on the bathroom door so the confused resident can identify the location of the bathroom;
  - Include interventions that may help the resident such as position, increased fluid intake, exercise and counseling.
The following are safe practices in most situations:

- Encourage the use of the toilet or commode instead of a bedpan;
- Recommend the resident wear clothing designed for easy removal. Elastic waistbands and Velcro closures work well;
- Remind in an appropriate manner. A memory-impaired person may remember childhood terms such as “potty.” If such terms are used, be sure everyone understands this is not meant to demean;
- Provide plenty of fluids unless there is a medical order that directs otherwise. A full bladder sends stronger messages to the brain;
- Encourage complete emptying of bladder before bedtime and immediately after getting up in the morning.
MANAGING INCONTINENCE CONTINUED

- Step three - Implement care plan:
  - Follow toileting schedule. Remind the resident to go or take the resident to the toilet at scheduled times;
  - Help promptly. This can reduce anxiety about reaching the bathroom in time and may decrease frequency of requests to be taken to the bathroom.

- Step four - Evaluate the plan:
  - Ask yourself how the plan is working. Is the resident responding with fewer accidents?
MANAGING INCONTINENCE CONTINUED

- Step five - Update the plan:
  - Consult the care team for additional ideas or if incontinence continues despite retraining and treatment. Discuss the problem with the resident, the family and staff.

- Incontinence is a time-consuming and expensive you can help lessen the problem:
  - Affirm the resident’s sense of dignity. If you do not have the resident’s trust and confidence, you will have a more difficulties trying to help deal with incontinence;
  - When an “accident” occurs, offer your assistance by saying, for example, “Let me help you freshen up.”
SPECIAL CONSIDERATIONS

- Protect the resident from skin breakdown and other problems related to incontinence such as unpleasant odors:
  - Encourage proper hygiene;
  - Be sure the skin is kept clean and thoroughly dry;
  - Recommend wearing absorbent disposable padding to assure confidence in participating in social activities and to protect clothing and bedding;
  - Urinary catheters are used for a medical treatment when the bladder is not working normally and should not be used for anyone’s convenience.
SPECIAL CONSIDERATIONS CONTINUED

- Remember, you might come in contact with body fluids while helping a resident. If you do:
  - Wash your hands with soap and warm water before *and* after helping a resident;
  - Wear disposable gloves.
DISCUSSION/QUESTIONS