Int J SPHM ▪ Volume 12, Number 1, 14-19 ▪ Copyright © 2022 Visioning Publishers LLC

International Round Table Discussion: The Challenges of Providing Dignified Bathroom Care

Participants:
Peg Graham, Owner, QUA (USA)
Hanneke Knibbe, Owner, DGA LOCOmotion (The Netherlands)
Rhonda Turner, RN Operations Support Specialist, Banner Health (USA)

Introduction

One of the most fundamental and essential elements of providing good care for patients in whatever setting, is to adopt a dignified and respectful approach to assisting them to the bathroom. For many patients the loss of the ability to be independent in this most private activity can produce a lot of stress and potential complications. It is not unusual for a patient to tell you they don't want to drink as that means they need to go to the toilet. Not only does this increase their risk of UTI, and constipation, but can also lead to the very problems they actually fear, such as incontinence. Providing the balance between safety (more falls occur in and on the way to the bathroom) and privacy is a challenge but when managed correctly, can make a big difference to how the patient perceives their stay in a facility setting or when being cared for at home. This round table discussion between 3 expert clinicians and researchers from the USA and The Netherlands discusses these challenges and some of the solutions to providing an optimum, safe, dignified bathroom experience.

Keywords: falls prevention, patient safety, toileting, bathroom, safe patient handling, technology

Moderator (MOD): Please introduce yourselves and tell the readers a bit about yourselves and how you became interested in this area.

Rhonda Turner (RT): I have been in healthcare for 36 years in various roles. I currently work as an RN Operations Support Specialist on a med-surg line. I support onboarding, education, quality metrics, and strategic initiatives. I also am very passionate about fall prevention, safe patient handling, and early mobility. Even though this has been my passion my entire health career, in 2019 it became personal. My loved one was left alone on the bedside commode in a hospital setting, fell, and broke her hip. She was even on video monitoring because she was a known extreme high fall risk. It was very different moving from bedside caregiver and instructor to being the family member. Heartfelt lessons throughout the entire journey.

Hanneke Knibbe (HK): I am a human movement scientist, physical therapist, and owner of DGA LOCOmotion, Research in Health Care. I became interested in the topic when the success of ergonomic programs depended very much on how toileting and assistive devices and continence care (containment material, skincare, etc.) were taken care of. In the early days (25 years ago), there were facilities where nurses and nursing aides spent more than half their working hours on direct or indirect continence care. I still find it intriguing and challenging to find solutions to enable independent toileting and if that is not possible anymore, to find solutions tailored to every patient's needs and wishes when it comes to a sensitive subject like this. I have high expectations of the technological devices that help patients' toileting and reduce the workload for nurses.

Peg Graham (PG): I have been working on toileting dependence since 2004, inspired by the determination of my mother to maintain her toileting independence as she aged with post-polio syndrome. Upon her death in 2004, I began to teach myself about assistive devices and toileting, starting with the work of Emily Agree and Vick Freedman (early advocates for the role of equipment in offsetting the loss of function). That led me to create the PPAL®, an innovative bedside commode designed to let older adults use their own transfer skills to move between commode and bed, reducing the need for manual lifting by caregivers.

In 2020, in a program sponsored by the Institute on

Disability, Independent Living and Rehabilitation Research, I interviewed 35 subject matter experts, including patients, direct care workers, chief medical officers, chief innovation officers, durable medical equipment providers, complex rehabilitation therapy, and safe patient handling and mobility professionals. As a result of that experience, I learned that the PPAL® was highly responsive to the needs of safe patient handling and mobility programs. In that same year, my company, QUA, was awarded a Phase I Small Business Innovation Research grant by the NIH to develop and study the safety/feasibility of the PPAL®, (https://reporter.nih.gov/search/VQhfSzzXZUi-5TKz4oqebg/project-details/10070007). We just learned that we have been accepted into the NIH's Innovation Corps (https://grants.nih.gov/grants/guide/pa-files/par-22-073.html), which involves another round of intensive interviews with toilet transfer experts, and I hope that readers of this discussion will be open to being interviewed.

MOD: How can caregivers get in touch with you if they would like to be a part of your research?

PG: I can be contacted directly at pgraham@quainc.com.

MOD: Why is patient dignity over staff safety such an important consideration in SPHM?

PG: I don't see that one is "over" another—I see the two as inherently linked. When it comes to toileting, we have a personal "need" that presents several times a day, involves human waste, and if left unattended in the moment, leads to a harmful, undignified impact on the patients, such as sitting in soiled sheets or having accidents at the bedside. As I understand it, the National Database of Nursing Quality indicators[1] includes a measure that captures patients' tendency to overestimate their ability to self-ambulate and they either walk to the bathroom or transfer onto a commode by themselves. This not only puts them at risk for fall/injury, it also endangers the safety of staff who attempt to rescue them.

From the staff side, I can only imagine the pressure that staff feel when they know they are keeping someone waiting, or they find themselves having to locate a lift, set up the lift, operate the lift – all the while knowing that the patient is highly agitated, wanting "to go." Neither patient nor staff can be very happy about that. And it need not just be getting a lift, the pressure to make the time also presents in situations where the staff have to bring/remove a bedpan or even assist with walking to the bathroom – that sense of patients' toileting urgency can be draining on staff coping with a busy unit.

RT: I have seen some severe falls happen while in the shower and especially around the need to go to the bathroom or if they are left in the bathroom alone. It is a fine balance to place safety over privacy. I have found that creating a partnership with patients and their family members helps to ease that privacy concern. The other concern is that humans are multitaskers, and many caregivers tend to think that the patient is busy in the bathroom, that would be the time to make the bed or get some charting in, and then that patient falls. Utilizing SPHM technology helps ensure that patients are safe, and staff are more focused on the task.

HK: I find that in most cases there does not need to be a choice of one over the other, but it also has to do with the design of the bathroom, the number of bathrooms available, the equipment available, and the technology in use. Sometimes a proper design of the incontinence material can offer more independence, more trust, and better continence levels. Some types can be worn as a precaution and can help train people and give them confidence. Also, assistive devices like bladder scans and sensors in incontinence material can help to find the best solution per patient, but also offer them more privacy.

For example, we used to do the bladder diaries for 3 x 24 hours. This is part of our guidelines when patients are admitted and are at risk of developing incontinence or are incontinent. For a lot of patients, this was considered an invasion of their privacy, they experienced a big threshold to discuss the difficulties they had in reaching the toilet or losing urine. It is a sensitive subject. Now, we are running a trial (stepped wedged design with 9 teams in nursing homes and home care) to test sensors that offer a far more precise 3 x 24 hours assessment and less invasion of privacy and hopefully a better continence care plan. They only have to wear this material for 3 x 24 hours and their continence is monitored automatically.

MOD: Hanneke, you conducted a study on disabled people and their dignity when being transferred with hoists. Can you tell us more about that and the impact on patient dignity?

HK: It is an old study, but the main finding was that nurses have beliefs and tend to project that on the patient without asking or opening the discussion with the patient. The result is a self-fulfilling prophecy of thinking the patient will not like that/want that, etc., whereas when we interviewed the patients they did not feel like that and had other priorities.

PG: If I may, I'd like to offer insight on this question. Part of why I thought we should be "asking more of the bedside commode" is because of my Mom's reaction to the choice of a lift when she could no longer bear any weight. She refused, describing that as being hoisted about "like cattle." She preferred using the bedside commode because, though she needed a lot of help to do it, she was managing to get on/off herself, with no one needing to lift her.

MOD: What do you all see as the main challenges to patient/resident dignity in the bathroom?

PG: I think the lack of dignity begins before the patient even gets into the bathroom. Let's face it, when you need help with toileting, you are vulnerable. And this prompts me to ask, "Just why are rates of toileting-related staff injuries so persistent?" Is it really because staff won't use safety devices? Or could it be that the current array of toileting devices is simply not effective when it comes to this frequent, messy need? I know from my interviews that many patient room bathrooms are too small for lifts. Nurses simply find it easier to use their own bodies to transfer patients (often referred to as "body mechanics"), putting themselves and their patients at risk for falling or musculoskeletal injury.[2]

RT: I have found that patients' privacy is a big concern. I believe that it is the way we approach the topic. If a caregiver comes across as nervous about helping patients in the bathroom, that can be sensed by the patients. It is important to be conscious of how caregivers are approaching the topic. If it is done so with confidence and respect, it will be better received by the patient.

HK: Due to the extreme workload, often patients are "made" incontinent although they could have remained continent with the dignity associated with it.

I think with improved equipment (aids, ceiling systems, special frames), better containment design/quality, etc. Furthermore, e-health devices that can assist in promoting the use of the bathroom in a dignified way, as well as sensors that offer a 3 x 24 hours assessment of the continence profile, bladder scanners, and apps that are available to promote patient dignity, and a continence care plan that is tailored to the specific needs and wishes of the patient can be created.

A technical challenge lies in the lack of a proper device that will allow passive patients to toilet comfortably if they so desire. The active lifters are fine and allow for proper toileting, privacy time, cleaning, and changing pads. The passive lifters and ceiling lift systems still present difficulties in removing clothes, changing pads, cleaning, and in providing a comfortable position on the toilet or commode chair. There are devices that do work), but they only accommodate part of this group. So, I hope that designers will develop something really good in the near future.

MOD: I want to share some real-life scenarios with you that relate to patient/resident dignity and toileting and get your thoughts on what the solutions are.

Scenario 1: A SNF was recently cited because a resident was taken to the bathroom using a sit-to-stand lift and whilst sitting on the toilet the sling had been left attached to the lift? What are your thoughts on this and the solution?

PG: I say take the whole process out of the bathroom and make the bedside commode more functional. Once you do that, you can then add other improvements: size and appearance that allow it to be kept at the bedside; a waste management system that segregates the urine/feces and makes disposal "user friendly" for both the patient and the staff – I am sure that there are other improvements that people can come up with. As more facility-based care moves to private rooms, both acute and SNF, bedside commode use becomes more palatable but only if redesigned with that in mind.

MOD: In the UK, the collection bucket in the commode is made of compressed paper. Once it has been used

the whole container is placed into a macerator and that is the last you see of it. I was surprised not to find this system in use when I came to work in the USA.

HK: Depending on the type of device, the assessment of the patient, and the design of the bathroom, this will or will not be a good solution.

RT: I would have to share how safety was a concern, not only for the patient but for the caregiver as well. I would ask if the caregiver was staying with the patient or if the patient was left alone; that would be two completely different scenarios. Being left alone with SPHM technology attached could be a reason to be cited, so I would agree with the citation. However, if the caregiver was with the patient, that would not be a citation from my perspective.

MOD: *Scenario 2:* In a rehabilitation unit, none of the patients were able to go into the bathroom to use the toilet as the doorway was very narrow. Your thoughts on this and your solutions?

PG: I refer to my prior answer.

RT: There needs to be some redesign for the bathrooms in this situation. I have seen hospitals that have bathrooms right in the room with privacy curtains around them. I have to say, that would also be awkward for patients. I would imagine that the staff was very creative in ensuring privacy and dignity at this facility. Careful consideration when building the facility must be taken and with something as important as narrow doorways, this must be fixed.

HK: This is a no-go...this should not/must not happen; widen it asap!

MOD: *Scenario 3:* The bathroom is so small that it is impossible to take the patient into the bathroom on a lift as there is no space to maneuver the technology? What are the risks and solutions?

HK: Use flexible systems in the bathroom (toilet itself, handrails, move sink out of the way, tidy it up, etc.), use a proper ceiling system, get a builder in, and if nothing is possible, offer second-best options for toileting (commode chair in a private room). We do not favor the use of commode chairs in The Netherlands unless there is no other way. Most patients will not like the idea of not being able to go to the bathroom and or the idea of having to pee in their room. We tend to use them only for the exceptions or during the night to avoid patients walking insecurely to the bathroom and falling. If necessary, it can also be discussed (with the patient and in the perspective of the care plan/ prognosis) that the patient makes use of high-absorbent incontinence material to ensure a good night's sleep, less fear of losing urine, helps prevent embarassment, and protects the skin.

PG: I suspect that some would say, "Move to single rooms and make the bathrooms large enough to accommodate wheelchairs and lifts." I think that the real issue is to reduce the labor from others required for toileting assistance and replace it with equipment that enables the patients to perform more of the tasks themselves. Move the toilet out of the bathroom, ie, a commode, but make that commode function at a higher level. When it comes to toileting, NO ONE should need to wait for someone to help – we should be designing equipment that enables them to do more for themselves.

RT: Again, there must be a consideration in the planning and design of the facility. I have been in situations where the SPHM technology doesn't fit or is difficult to maneuver. It puts the caregivers at risk for injuries as well as the patients. I have learned to first try it without the patient. If there are any concerns at all, then a different option must be taken into consideration, such as using a bedside commode.

MOD: Bathroom or bedside commode? Your thoughts?

RT: Every situation is different and must be evaluated prior to assisting the patient. I have worked in every healthcare setting on my 36-year journey with 25 years of experience in a hospital setting. Early in my career at the hospital, I worked in a pediatric/adult surgical unit. Patients had to share one tiny bathroom between two hospital rooms with a total of 4 patients using each bathroom. There were many times I opted to use a bedside commode and those bathrooms certainly could not accommodate any SPHM technology on the market today. I recall one time when I was assisting a male to the bathroom, and it was his first time after surgery. He was well over six-feet-tall; he was using the urinal, and he passed out. I called my coworker in and we were stumped. Thankfully, this small bathroom was a gift in this situation as he just simply leaned against the wall, and it was supporting him to prevent him from falling. He woke up in time before we had to troubleshoot how to get him out of that situation. I was so grateful when the hospital moved to all private rooms and the units that shared bathrooms were closed.

PG: I think that, when responding to this question, we tend to revert to the bedside commode as it exists today. Let's re-imagine what it could look like; if patients could move themselves on and off, if it managed the waste in a more user-friendly way, and if it looked appealing? What then? Importantly, if patients found it to be an attractive alternative to "going to the bathroom" multiple times of day, would staff find relief? Would we think differently about the commode?

The pricing would have to change to support the additional technology. It would be considered an investment that would have to be maintained, and just as patients are given a bed when they are admitted, a patient would be given one of these high-tech commodes. And just as the next patient gets that same bed after it has been disinfected, so too would the next patient receive that same high-tech commode. Throughout the useful life of the commode, reductions in toileting-related falls/injuries would more than pay for the cost of the commode. On top of that, there would be improvements in patient satisfaction and quality ratings on the patient side, improvements in retention/recruitment, and job satisfaction on the staff side.

HK: A commode can be a solution to prevent falls at night at the bedside. In the bathroom, a commode chair should not be necessary. The only exception is when a shower chair/trolley has a toileting option or the need to change containment material (with high/low tiltable shower chairs that can open in the genital area like a shower/toileting chair).

MOD: Are there any technologies you feel we need to develop to ensure we can meet all patient/resident needs in the bathroom.

PG: I am all about new technologies, as I've outlined in other parts of this discussion.

HK: Yes. I strongly believe in the new generation of sensors to accommodate the patients and help caregivers to offer healthy, easy, professional and efficient care in the bathroom 24/7 day and night. We are in a trial now with the University of Utrecht to study the effects and perform a CEA.

RT: I have seen facilities with ceiling tracks all the way into the bathroom and patients use walking harnesses all the way in, and they are safe. In the situation where the skilled nursing facility got cited for leaving the sling on, it would be optimal to have toilets where patients can be supported (perhaps some padded sides that can be moved out of the way) or with a safety belt on the toilet. Ensuring that there are nonslip floors throughout the bathroom, not just in the shower, would also be beneficial.

MOD: Do you have anything else you would like to add to this discussion?

PG: I take this opportunity to point out that we are all seeing demand for hospital, skilled nursing, and home care far outpace the available labor supply, largely due to the burnout of COVID-19-related stress on staff

but also driven by an ever-increasing number of older adults aging with chronic conditions. The old way of thinking about mobility—dependant tasks such as bathing and toileting—where the person is capable of the task but for the inability to ambulate—all of that may need to be re-examined.

HK: I agree.

PG: SPHM programs should also be considering the massive shift happening across the healthcare system towards value-based care and an openness to "hospital at home" initiatives. This means that this question of bathroom size presents, not just in hospitals and skilled nursing facilities, but in people's homes. As more care migrates to the home, the challenges of toileting dependency will travel with it. Many homes, particularly in lower-income neighborhoods, do NOT lend themselves to modifications. In other instances, the cost of the modification is cost-prohibitive.

SPHM programs would be well-served to start looking at the persistent causes of staff injury, such as transferring patients to/from bed/chair/wheelchair/commode and similar seated items and come up with solutions that apply across healthcare settings. For me, that means rethinking the bedside commode.

HK There is so much to win on the subject: both for the quality of care and the working conditions for nurses. In under-researched areas, innovations are underused. This area demands crossing the borders and integrating SPHM with other fields like continence care, skincare, etc. That offers a lot of new opportunities for making SPHM programs far more effective and the other way around. It also looks that the innovations in this field of toileting will make health care more efficient and better for patients.

RT: I just appreciate the conversation and presenting this fragile topic from an international perspective. The lessons learned along my healthcare journey and with my loved one have inspired me to continue to advocate with every opportunity. Falls can be devastating for all that are involved and can happen in the blink of an eye. A proactive approach with hands on training, proper SPHM technology, thoughtful design, and a strong interdisciplinary perspective will help to decrease injuries to patients and to caregivers. The training must include conversations around the importance of staying in the moment and with that patient at all times while they are up. One piece of advice when approaching the topic of being present with the patient is that I speak from the heart, "For my peace of mind, I prefer to stay with you until you are back in the chair or bed. I consider it an honor to ensure that you are safe."

MOD: Thank you for taking the time to share your expertise with our readers.

References:

1. Staggs VS, Turner K, Potter C, Cramer E, Dunton N, Mion LC, Shorr RI. Unit-level variation in bed alarm use in US hospitals. *Res Nurse Health*. 2020;43(4):365-372. doi: 10.1002/nur.22049
2. Noble NL, Sweeney NL. Barriers to the Use of Assistive Devices in Patient Handling. *Workplace Health Saf*. 2018;66(1):41-48. doi: 10.1177/2165079917697216

Research referenced in this publication was supported by the National Institute Of Nursing Research of the National Institutes of Health under Award Number R43NR019516. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

This international round table discussion was moderated by Heather M. Monaghan, MHSc, RN, Editor-in-Chief of the International Journal of Safe Patient Handling & Mobility.

The statements and opinions contained in the round table discussion are solely those of the individual contributors.

Let's Keep Talking!

Each round table discussion topic will be posted on the *International Journal of SPHM*'s LinkedIn page so be sure to join us to continue the discussion and share your experiences.