Queensland Health

# Tips for Managing Continence and Pressure Care in People who are Bedbound

Medical Aids Subsidy Scheme

26 March 2026

# Learning Objectives



- Define bedbound and pressure injury
- Understand unique clinical challenges for people who are bedbound
- Evidence based prevention and management strategies:
  - pressure injury prevention
  - continence
- Tips and resources

# Bedbound vs Bedridden

Bedbound for 15 days or more, spends more than 90% of their time in bed and required assistance in daily activities.

Bedbound people may have variable

- postural tolerance
- bed mobility
- Will have personal preference e.g. half-sit or be in bed-like furniture.

"Bedridden is defined as **permanently confined** to a bed and can not sit up or get out of bed independently and the most severe form have **lost the ability to reposition**, check or maintain their skin health."

Original Investigation | Geriatrics

**Bedbound Status During the Last Year of Life Among Community-Dwelling Older Adults**

Katherine A. Ornstein, PhD, MPH; Mary Louise Pomeroy, PhD, MPH; Hanna Charankevich, PhD; Po-Jen Kung, PhD, MSN; Orla C. Sheehan, MD, PhD; Christine S. Ritchie, MD, MSPH; Bruce Leff, MD; Jennifer M. Reckrey, MD

16.6% bedbound in their last year of life

People with dementia 5x more likely to be bedbound

77% bedbound in the last month of life

Singh T, Minhas A. (2015)Factors affecting quality of home based long-term care provision for the bedridden patients in Chandigarh, North India. Journal of Postgraduate Medicine, Education and Research.;49:126–131. Schirghuber J, Schrems B. Being wheelchair-bound and being bedridden: Two concept analyses. Nurs Open. 2023 Apr;10(4):2075-2087. doi: 10.1002/nop2.1455. Epub 2022 Nov 6. PMID: 36336822; PMCID: PMC10006658.

# Overlapping Clinical Considerations



Prognosis 6 months
PCEP eligible

**Bedbound**

Profound weakness
Cognitive impairments
Immobility
Contractures
Reduce metabolic
Reduce circulation
Orthostatic intolerance
Pressure injuries
UTI

Pain
Fatigue
Constipation
Respiratory issues
Nutritional difficulties
Emotional distress
Loss of independence

**Palliative Care**

Nausea and Vomiting
Dyspnoea (SOB)
Delirium
Anorexia and Cachexia
Anxiety & Depression

# Impacts of Immobility

| Reduced blood circulation and electrolyte imbalances | Intestinal dysbiosis (imbalance) | Respiratory and physical deconditioning |
| --- | --- | --- |
| • slow down tissue repair →contribute to chronic wound<br>• Muscle atrophy<br>• Renal dysfunction | • Reduce digestion → Microbiome shift (higher gut-related bacteria) → increase infection risk<br>• Increase constipation<br>• Change on bowel routine →increase infection and skin breakdown | • Increase fatigue<br>• Perpetuate poor circulation and muscle atrophy<br>• Risk of chest infection |
| +/- appetite/ nutritional intake | +/- opioids<br>+/- medication | +/- pain<br>+/- medication |

Open Resources for Nursing (Open RN); Ernstmeyer K, Christman E, editors. Nursing Fundamentals [Internet]. Eau Claire (WI): Chippewa Valley Technical College; 2021. Table 13.2a, [Effects of Immobility on Body Systems[]]. Available from: https://www.ncbi.nlm.nih.gov/books/NBK591828/table/ch13mobility.T.effects_of_immobility_on/
Complications of Immobility in the Elderly - Medstrom

# Pressure Injury Risk Assessment

# Skin Tear vs Pressure Injuries

**Skin tears** are traumatic wounds that may result from a variety of mechanical forces such as shearing or frictional forces, including blunt trauma, falls, poor handling, equipment injury or removal of adherent dressings.

**Pressure injuries**/ulcers are localized damage to the skin and/or underlying tissue, usually over a bony prominences or related to a medical or other devices, resulting from prolonged pressure or pressure in combination with shear.

Incidence of Pressure injuries

Community: 4.5–19.5% in **known wounds** in all age groups (Carville and Lewin, 1998; LeBlanc et al, 2008)

In palliative care: 3.3–14.3% (Amaral et al, 2012; Maida et al, 2012)

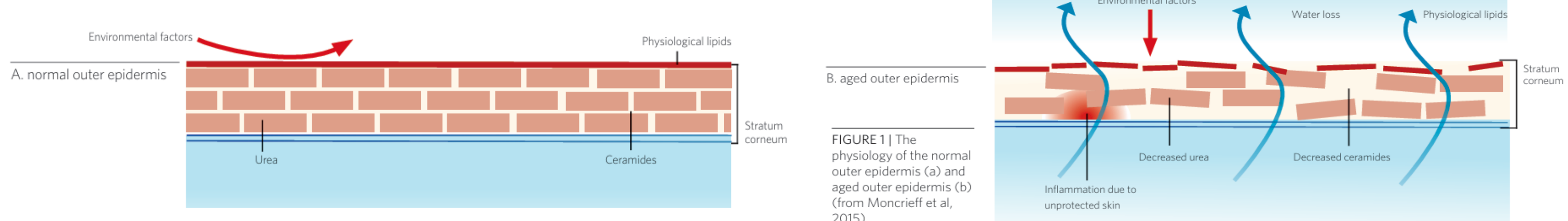


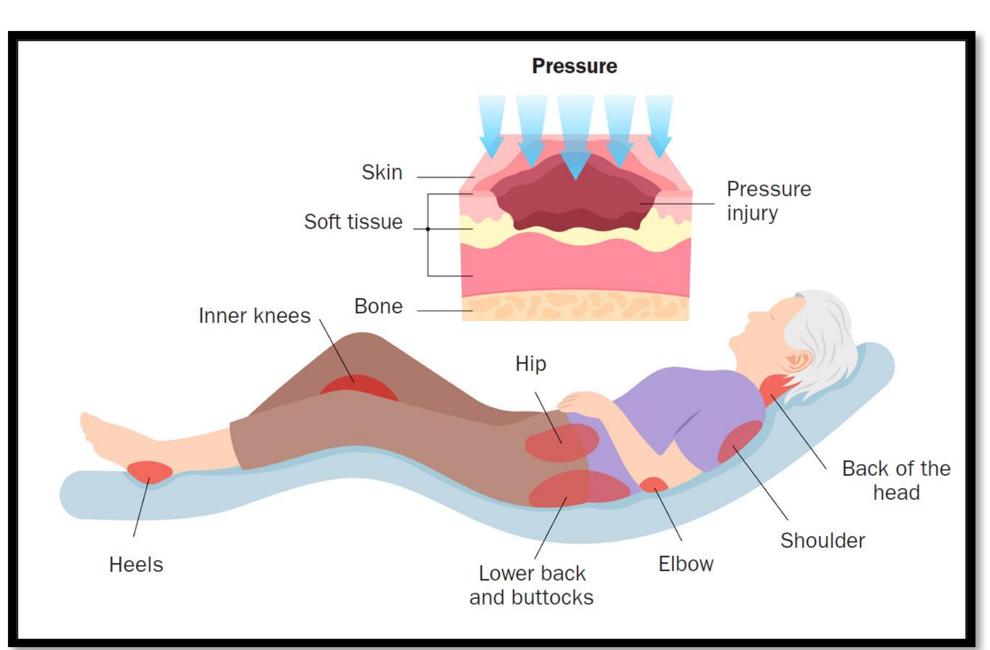

FIGURE 1 | The physiology of the normal outer epidermis (a) and aged outer epidermis (b) (from Moncrieff et al, 2015)

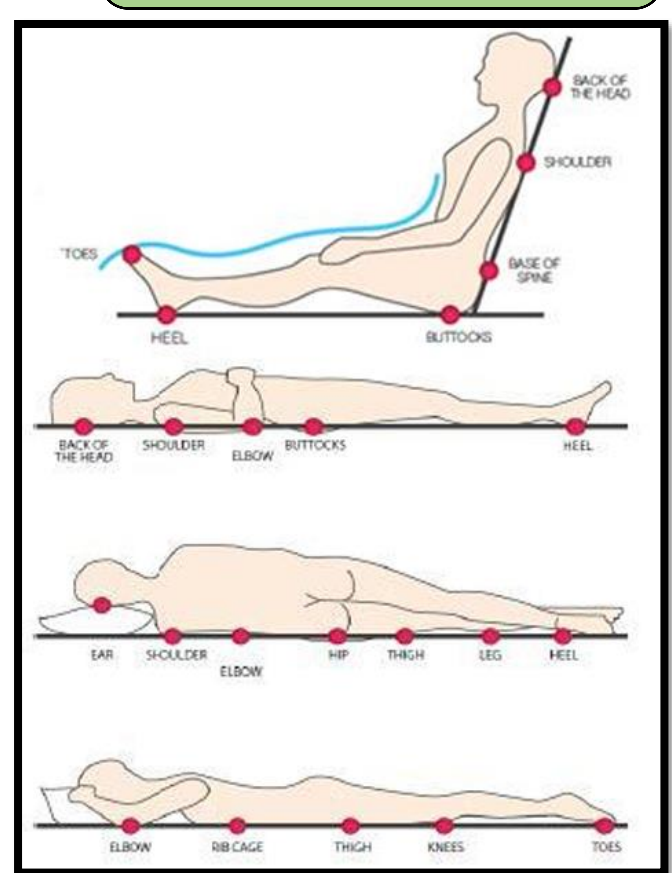

Wounds international, 2018. ISTAP best practice recommendation for the prevention and management of skin tear in aged skin. From 085aa82de6f9383340ed14a2d2eda3a1.pdf

Roussou, E., Fasoi, G., Stavropoulou, A., Kelesi, M., Vasilopoulos, G., Gerogianni, G., & Alikari, V. (2023). Quality of life of patients with pressure ulcers: a systematic review. *Medicine and Pharmacy Reports*, *96*(2), 123.

# Areas at Risk of Pressure Injury

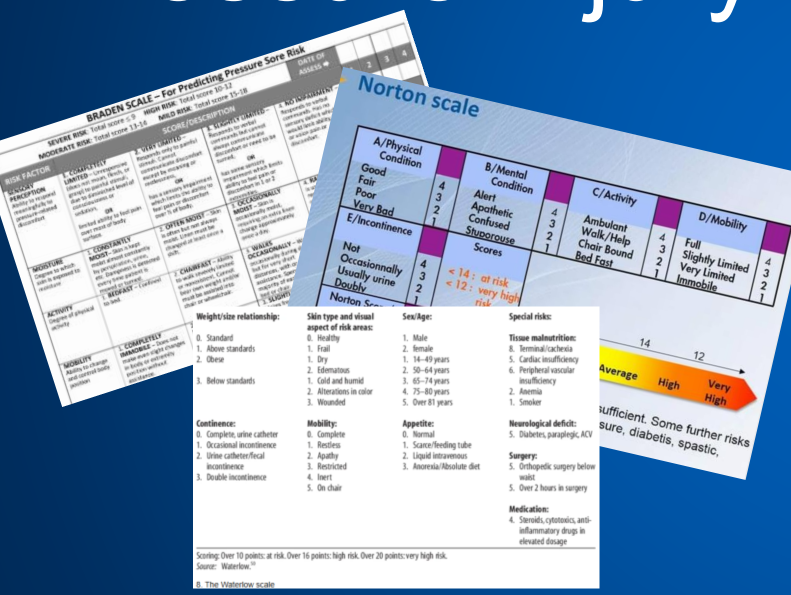
Consider if client's tubes, drains, plasters may contribute or cause a PI



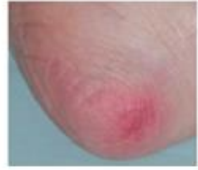




Acknowledgement European Pressure Ulcer Advisory Panel, National Pressure injury Advisory panel and Pan Pacific Injury alliance. Prevention and treatment of pressure Ulcers/Injuries. Clinical practice guideline. The international Guideline. Emily Haesler (Ed) EPUAP/NPIAP/PPIA:2019

# Stages of Pressure Injury

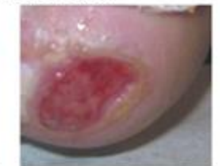



## Stage I: Erythema of skin only



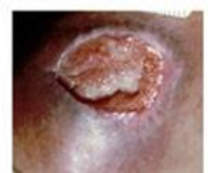
Unbroken skin with localised non blanchable erythema*. Red areas disappear within 30mins when pressure relieved.
Changes in sensation, temperature, colour changes (if non blanchable, deep red maroon or purple this may indicate deep tissue pressure injury) need to seek medical assessment.
*May appear different in darkly pigmented skin

## Stage II: Erythema with loss of partial thickness of the skin



Partial-thickness loss of skin with exposed dermis. Wound bed is pink/red, moist (viable). Fat or deeper tissues are not visible.
Normally present over pelvis due to microclimate and heel due to shear injury.

## Stage III: Full thickness ulcer that might involve subcutaneous fat



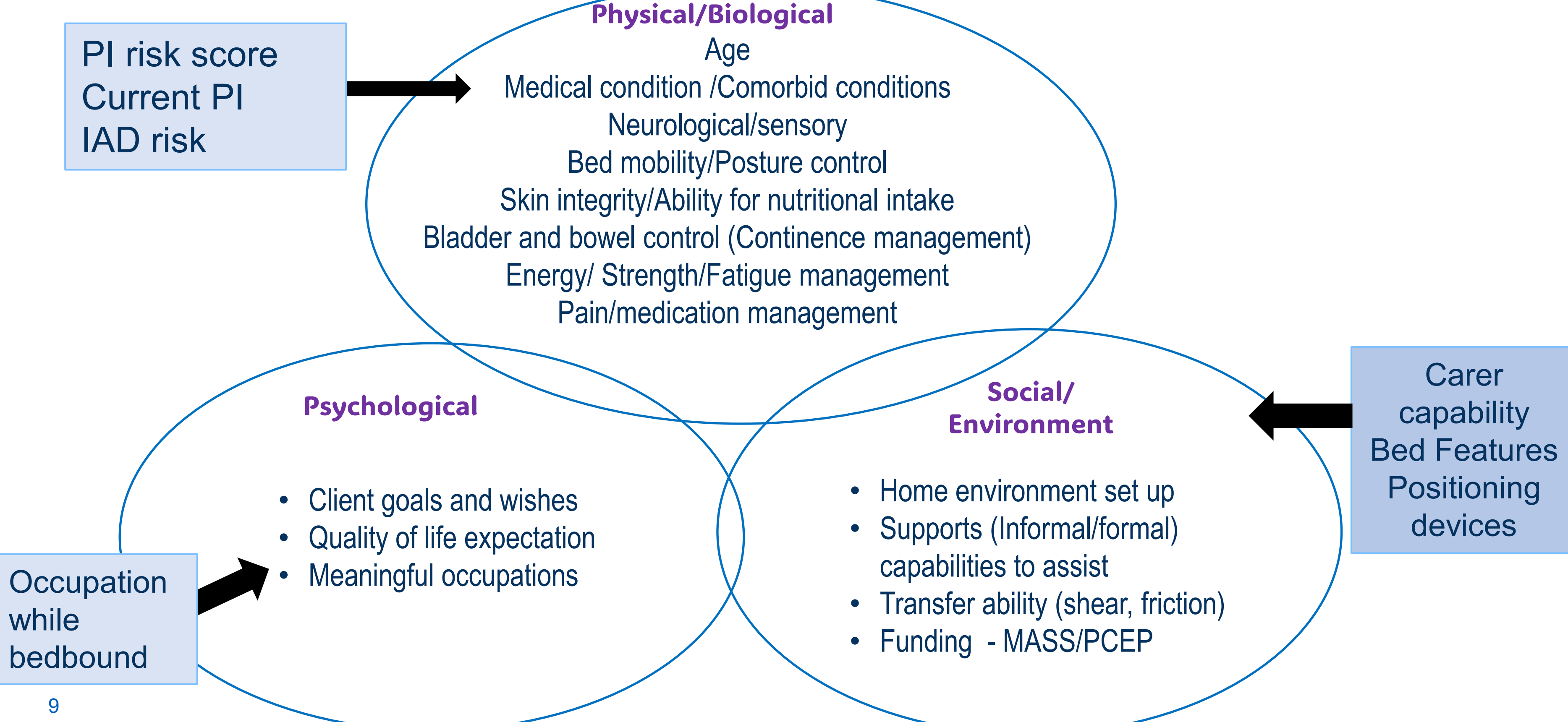
Full-thickness loss of skin. Fat is visible in the ulcer with granulation tissue and epibole (rolled wound edges). Slough (dead tissue) and/or eschar (dry leathery scab) maybe visible.
*Need to assess if tunnelling and if slough/eschar obscures extent of tissue loss.

## Stage IV: Full thickness injury with involvement of muscle or bone

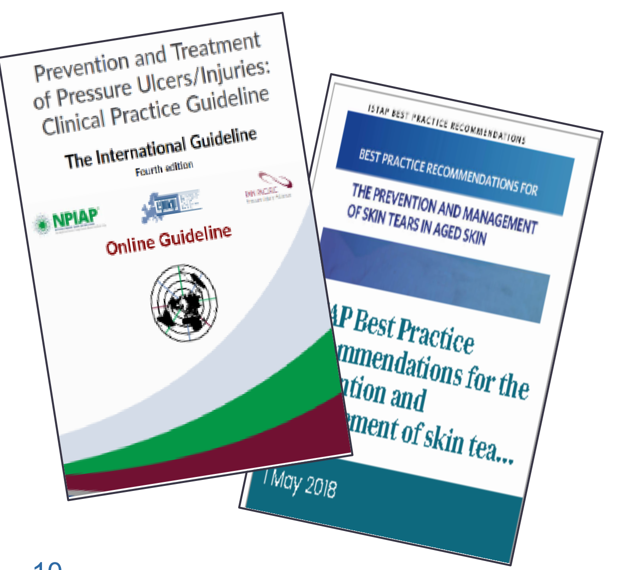
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bond in the ulcer. Slough/eschar maybe visible. Epibole, undermining and or tunnelling often occur, depth depends on body area.

Based on National Pressure Ulcer Advisory Panel (NPUAP), European Pressure Ulcer Advisory Panel (EPUAP). Prevention and Treatment of Pressure Ulcers: Clinical Practice Guideline. 2009, Washington DC: NPUAP cited in Australian Wound Management Association. Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury. Abridged Version, AWMA; March 2012. Published by Cambridge Publishing, Osborne Park, WA.

# Assessment Considerations for the Bedbound Client



# PRM Assessment forms / guides




[Spinal Outreach Team PRM Assessment Tool]

[SA Equipment Program Pressure Mattress Clinical Considerations]

# Pressure Care Management

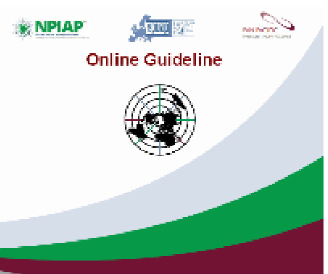
# Pressure Prevention and treatment guides

Pressure injury toolkit | Agency for Clinical Innovation

Prevention and Treatment
of Pressure Ulcers/Injuries:
Clinical Practice Guideline

The International Guideline

Fourth edition

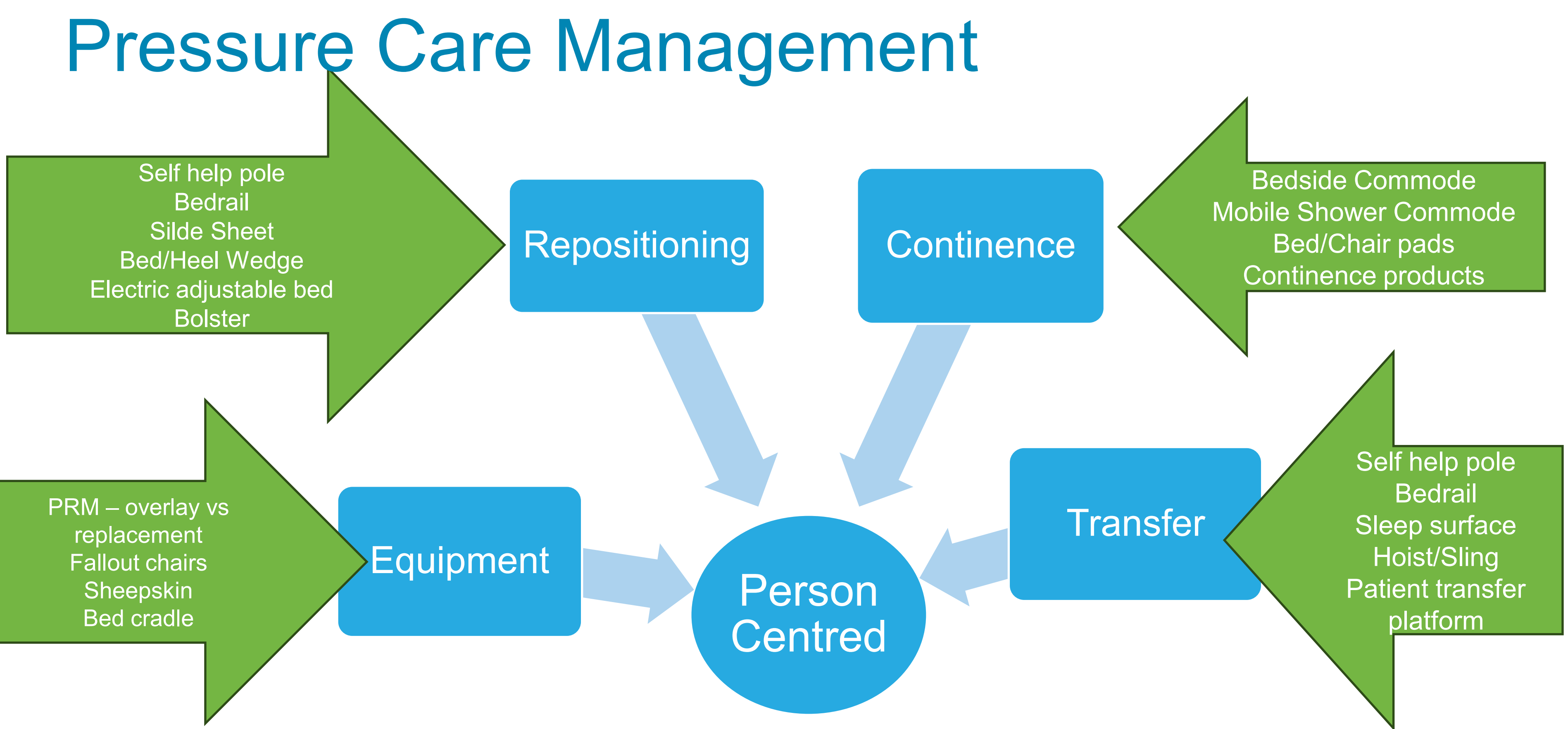



**Prevention and Treatment of Pressure Ulcers/Injuries Guideline (Online version)**

**Table 2. Optimal treatment of pressure injuries – factors to consider (including prevention strategies)**

| Factors to consider | Tips and notes |
|---|---|
| Engage the patient, family and carer in treatment | ■ Provide education through brochures, face-to-face interactions, skills training and psychosocial support<br>■ Listen to concerns and provide solutions to care practices within the environment |
| Manage pain | ■ Use a validated pain assessment tool relative to the person and context<br>■ Consider using non-pharmacological and pharmacological management strategies<br>■ Administer regular analgesia<br>■ Reassess pain levels following interventions<br>■ Consider the use of topical agents for pain relief |
| Optimise nutrition/ hydration | ■ Screen for nutritional risk using a validated tool<br>■ Refer to a dietitian for comprehensive assessment<br>■ Follow the international guideline recommendations for calorie (30-35 kcal/kg) and protein (1.2-1.5 g/kg) intake based on body weight |
| Mobilise and reposition the body | ■ Offload bony prominences and pressure injury sites<br>■ Encourage early mobilisation when appropriate<br>■ Implement individualised repositioning and mobilisation strategies<br>■ Promote early/ongoing mobilisation and micro turns/incremental turns when appropriate<br>■ Use manual handling supportive devices such as slide sheets<br>■ Consider the surface and the position of the bed e.g. no longer than 30 minutes seated mobilisation<br>■ Reposition as frequently as required for the individual's needs |

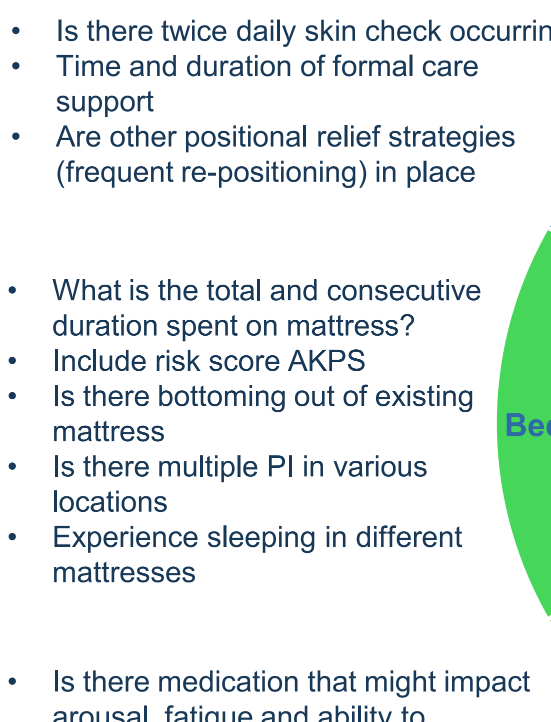
# Pressure Care Management





Gould LJ, Alderden J, Aslam R, Barbul A, Bogie KM, El Masry M, Graves LY, White-Chu EF, Ahmed A, Boanca K, Brash J, Brooks KR, Cockron W, Kennerly SM, Livingston AK, Page J, Stephens C, West V, Yap TL. WHS guidelines for the treatment of pressure ulcers-2023 update. Wound Repair Regen. 2024 Jan-Feb;32(1):6-33. doi: 10.1111/wrr.13130. Epub 2023 Dec 20. PMID: 37970711; PMCID: PMC11403384.

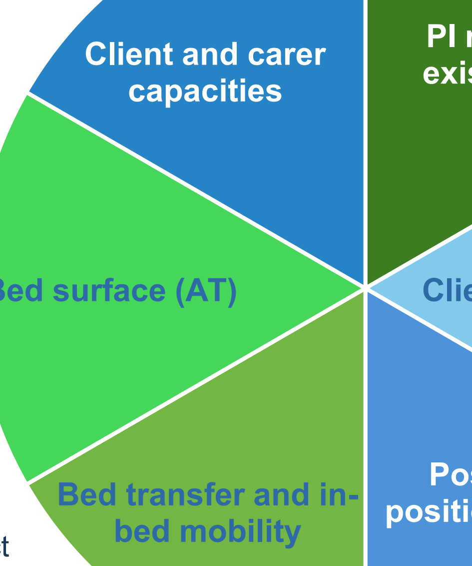
# Pressure Care Treatment Considerations



- Is there twice daily skin check occurring
- Time and duration of formal care support
- Are other positional relief strategies (frequent re-positioning) in place

- What is the total and consecutive duration spent on mattress?
- Include risk score AKPS
- Is there bottoming out of existing mattress
- Is there multiple PI in various locations
- Experience sleeping in different mattresses

- Is there medication that might impact arousal, fatigue and ability to reposition self



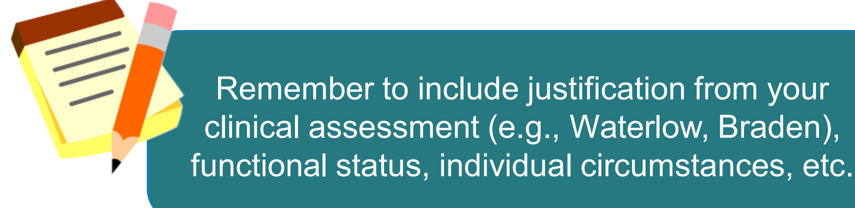

- Goal of treatment e.g. healing vs comfort and ease of care management
- Is there multiple PI in various locations
- Skin integrity compromised by moisture (microclimate/continence issues)

- Is there significant weight loss
- Is there reduction or change in nutritional intake
- Is there medication that might impact arousal, fatigue and ability to reposition self
- Comfort/preference
- Impacted by motion sickness
- Frequency of bowel and bladder care
- Funding scheme/eligibility

- Tolerance/routine to sit out in chair (mindful if existing PI)
- Can side lying wedges or other positioning equipment possible on current mattress

# Pressure Care
# Equipment Prescription

# Eligibility




## MASS [Link to guidelines]

- Queensland resident with administrative eligibility (e.g., Qld Senior Card, Pension)
- Basic subsidy ($2,500) = at risk of, and/or current, PI
- Non-based subsidy ($6,000) = significant history of PI and/or severe mobility restriction
- Successful 3-night trial
- Single or king-single ‡

## PCEP [Link to guidelines]

- Queensland resident with confirmed prognosis < 6 months
- AKPS score ≤ 50*
- RUG score ≥ 10*
- Single †

* Or other score with clinical justification assessed by PCEP advisor
† King single available with clinical justification
‡ May get larger, but subsidy based on single / king single equivalent

# Classification of Pressure Redistribution Mattresses

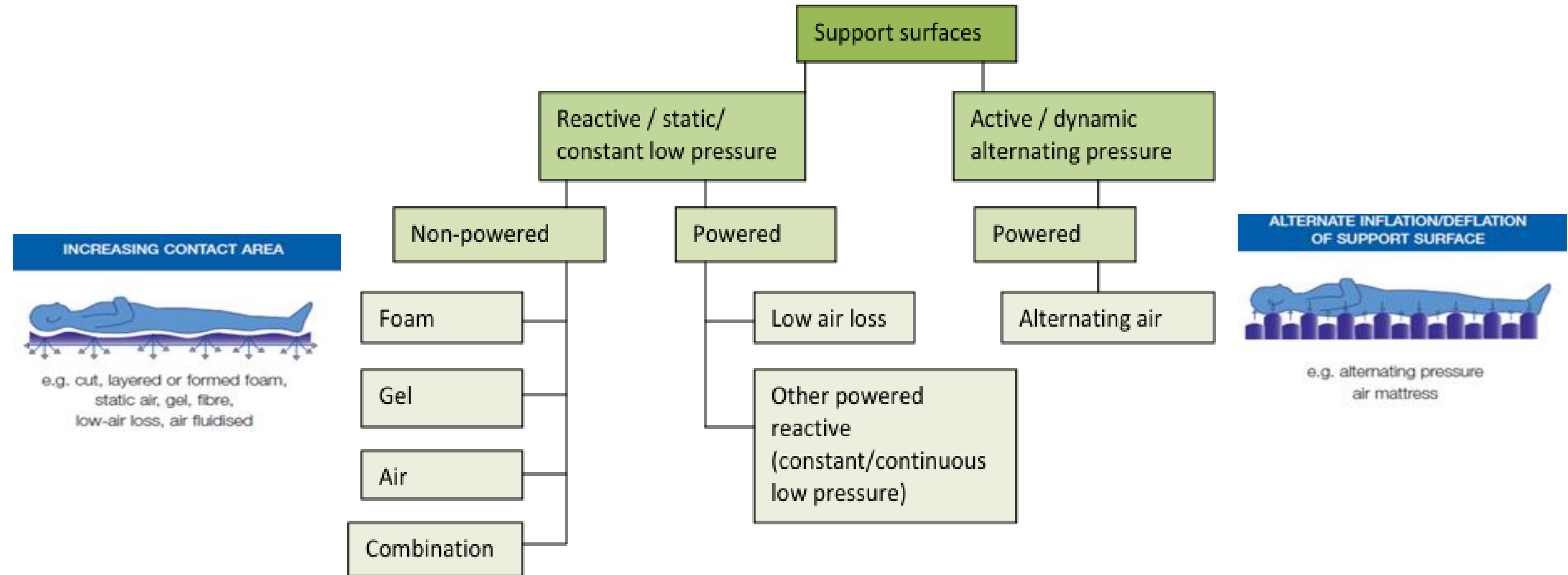



Diagram taken from **Spinal Outreach Team PRM Assessment Tool**

# Overlay versus Mattress Replacement

## Overlay

- May be easier for bed mobility and transfers
- Pressure relief may be sufficient for people with low body weight
- Can sometimes be used on a recliner chair as well as a bed
- May be more cost effective

## Mattress Replacement

- May be more effective for people with very limited mobility
- More effective for people with bariatric needs as can provide air flow and keep skin temperature lower

1. SA Health. Guide tor selection of devices an equipment to reduce skin pressure. Link

# Pressure Mattress Research

May be more effective

## Preventing PIs

reactive air surfaces

foam surfaces plus four-hourly turning

alternating pressure (active) air surfaces

reactive sheepskin surfaces

foam surfaces

standard hospital surfaces

May be less effective

## Treating PIs

reactive air surfaces

alternating pressure (active) air surfaces

reactive water surfaces

foam surfaces

Repose mattress was more effective and cost effective than alternating air[2]

High-spec foam vs alternating air No significantly difference with reduction of PI risk when cost effectiveness also considered[3]

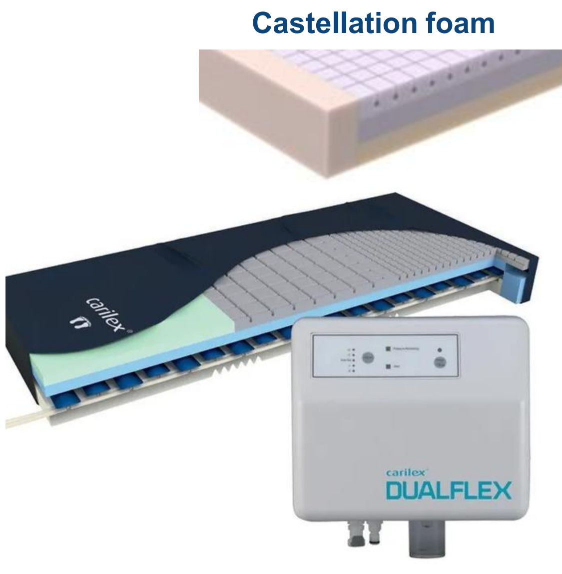
Shi C, Dumville JC, Cullum N, Rhodes S, McInnes E, Goh EL, Norman G. (2021) Beds, overlays and mattresses for preventing and treating pressure ulcers: an overview of Cochrane Reviews and network meta-analysis. Cochrane Database of Systematic Reviews, Issue 8. Art. No.: CD013761. DOI: 10.1002/14651858.CD013761.pub2. Accessed 20 March 2026.
Beeckman, D., Serraes, B., Anrys, C., et al. (2019). A multicentre prospective randomized controlled trial comparing the effectiveness and cost of a static air mattress and alternating air pressure mattress to prevent pressure ulcers in nursing home residents. International Journal of Nursing Studies, 97, 105-113. doi: 10.1016/j.ijnurstu.2019.05.015
Nixon, J., Brown, S., Smith, I.L., et al. (2019). Comparing alternating pressure mattresses and high-specification foam mattresses to prevent pressure ulcers in high-risk patients: the PRESSURE 2 RCT. Health Technology Assessment, 23(52), 1-176.
Link

# MASS PCEP Top 3 Mattresses Requested

Centrius overlay system

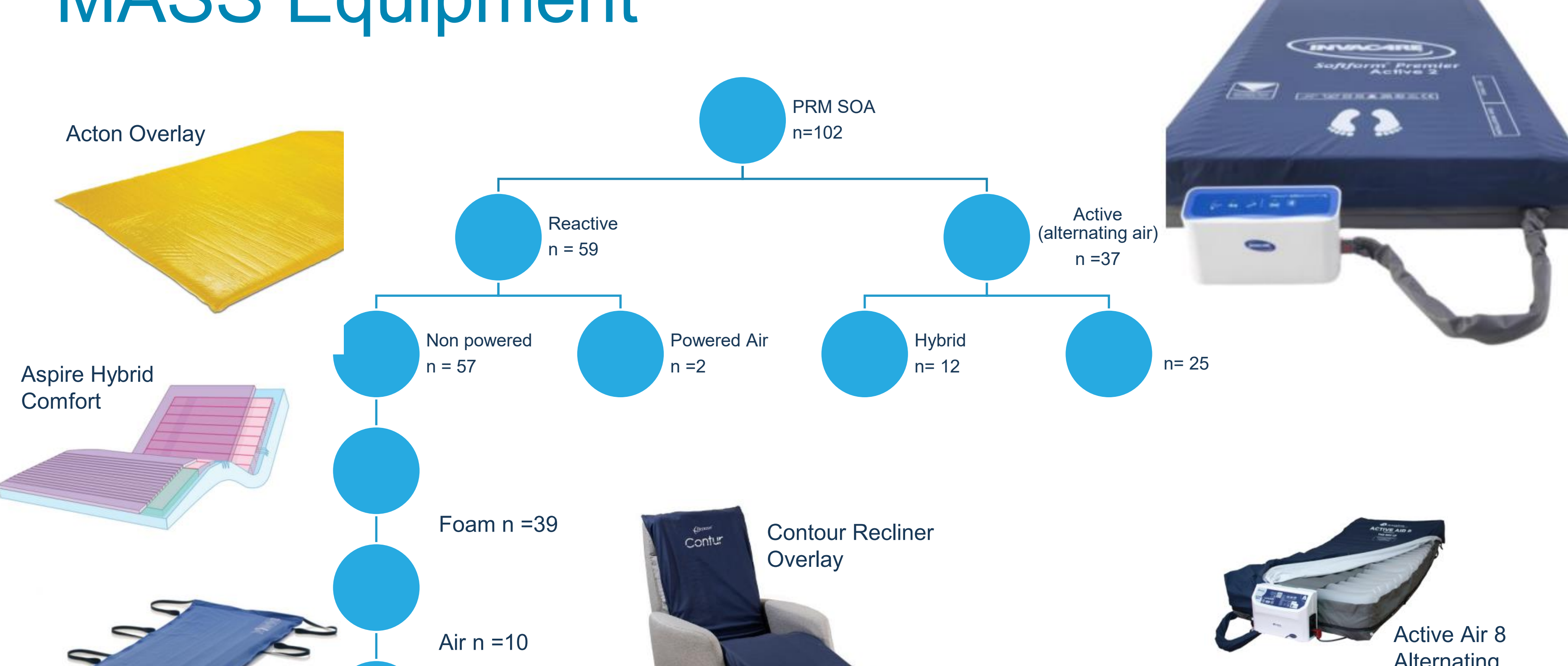
Centrius replacement system

Castellation foam




Dual Flex Hybrid mattress

# MASS Equipment




**Link to SOA spreadsheet**

# Marcus

- 67 year old male
- Palliative - pancreatic cancer
- Previous radiation therapy
- Decreased skin integrity
- Impaired thermoregulation
- No previous pressure injury
- Continent
- RUG-ADL 16
- AKPS 30

Goal: Wanting to stay in standard bed

# Considerations of Pressure Care and Continence

- Weigh up the benefit vs risk
- User acceptance and care support
- Consider what is used on pressure redistribution mattress
  - Tightly applied sheets non stretch coverings (sheets)
  - Continence barriers
- Consider preventative dressings for individual with incontinence (eg. Frequent loose stools)
- Risk of skin irritation
- Risk of moisture-associated skin damage
- Risk of damaging surrounding skin integrity and

Be careful of what is used on a pressure mattress as they can interfere with immersion and off-loading functions

Acknowledgement European Pressure Ulcer Advisory Panel, National Pressure injury Advisory panel and Pan Pacific Injury alliance. Prevention and treatment of pressure Ulcers/Injuries. Clinical practice guideline. The international Guideline. Emily Haesler (Ed) EPUAP/NPIAP/PPIA:2019

# Repositioning Tips:

# Repositioning Research

Update of a review first published in 2014 – additional 5 studies

**Objective:** To assess the clinical and cost effectiveness of repositioning regimens(i.e. repositioning schedules and patient positions) on the prevention of PI in adults regardless of risk in any setting

**Data:** Eight (8) trials involving 3941 participants from acute and long-term care settings and two (2) economic sub studies. Follow-up periods were short (24 hours to 21 days)

**Conclusions:** The evidence was judged to be of low or very low certainty. Economic: Limited data. Unclear whether repositioning every three hours using the 30° tilt versus "usual care" (90° tilt) or repositioning 3-to-4-hourly versus 2-hourly is less costly relative to nursing time


Gillespie BM, Walker RM, Latimer SL, Thalib L, Whitty JA, McInnes E, Chaboyer WP. (2020) Repositioning for pressure injury prevention in adults. Cochrane Database of Systematic Reviews, Issue 6. Art. No.: CD009958. DOI: 10.1002/14651858.CD009958.pub3. Accessed 20 March 2026.

# Repositioning Equipment

Bluestein D, Javaheri A. Pressure ulcers: Prevention, evaluation, and management. Aafp.org. 2022. [Last accessed on 2022 Jun 26]. Available from: https://www.aafp.org/pubs/afp/issues/2008/1115/p1186.html

# Transfer Aids

Not subsided through MASS

**Self help pole (goose neck)**

Slide sheet

WendyLett

Wonder Sheet

Wonder Plus

# Manual Handling Tips:

# Manual Handling Research

## Inherent Risk

- High rates of **musculoskeletal injuries (MSDs)** in healthcare
- Highest risk tasks:
- Transfers (bed ↔ chair)
- Repositioning
- Sit-to-stand
- **Manual lifting = unsafe spinal load**

## What Research Shows 🔍

- Training alone ❌ **does NOT reduce injuries**
- **Environment + equipment = biggest impact**
- Poor setup = ↑ injury risk
- Patient participation =
  ✓ safer transfers
  ✓ better mobility outcomes

## Practice

- Use **mechanical aids** (hoists, slide sheets)
- Optimise **environment**
  - bed height
  - chair height
  - space to move
- Apply **no-lift / minimal lift approach**
- Promote **mobility, micro adjustment independence**


Coman, R., Caponecchia, C., & McIntosh, A., (2018). Manual Handling in Aged Care: Impact of Environment-related Interventions on Mobility, *Safety and Health at Work*, Volume 9, Issue 4, Pages 372-380. https://doi.org/10.1016/j.shaw.2018.02.003.

Caboor, D. E., Verlinden, M. O., Zinzen, E., Van Roy, P., Van Riel, M. P., & Clarys, J. P. (2000). Implications of an adjustable bed height during standard nursing tasks on spinal motion, perceived exertion and muscular activity. *Ergonomics*, *43*(10), 1771–1780. https://doi.org/10.1080/001401300750004177

Tsuji, S, Tsujimura, H, Shirahoshi, S, Taoda, K & Kiyahara. (2023). Effects of different bed height o the physical burden of physiotherapist during manual therapy: an experimental study. *Industrial Health* 61, 213-221.

Murtagh, E (2015). Required Caregiver Forces While sliding a patient up in bed using a variety of bed heights. University of Toledo Thesis. Access 18/3/2026 on https://www.utoledo.edu/library/projects/OccTherSP_Murtagh_Elise.pdf

Alperovitch-Najenson,D., Milyoner,S., Horesh-Sztulman,D., Weissberger, O., Ezra,D. & Kalichman, L. (2022). Optimal bed height for passive manual tasks, *Journal of Bodywork and Movement Therapies*, 29, 127-133.

# Pragmatic considerations

Best Practices for Cleansing, Disinfecting, and Care of Polyurethane Support Surface Covers

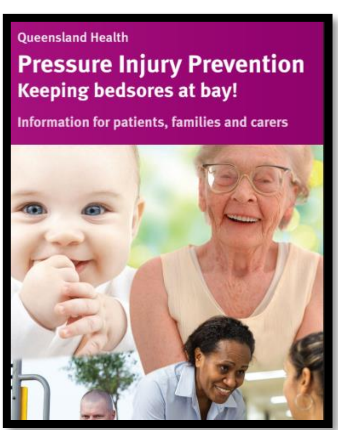
NPIAP Best Practices for Cleansing, Disinfecting, and Care of Polyurethane Support Surface Covers

- Your training and competence (Beeckman et al., 2019)
- Do carers know how to
    - adjust settings,
    - manage inbuilt alarms,
    - Plan to change sheet (incontinence related hygiene/infection control)
    - Is there a plan to power disruption or mattress failures (e.g., powered air mattresses, low pressure, power fail, pump fault) or can this be locked?
    - Transfer to alternative surface/attend appointments
- Have power and air cables been managed safely (e.g., trips and falls)?
- Availability of materials and resources (Beeckman et al., 2019)
    - MASS SOA
    - Supplier stock
    - PCEP loan pools
- Access to repairs and maintenance

Beeckman, D., Serraes, B., Anrys, C., et al. (2019). A multicentre prospective randomized controlled trial comparing the effectiveness and cost of a static air mattress and alternating air pressure mattress to prevent pressure ulcers in nursing home residents. *International Journal of Nursing Studies, 97*, 105-113. doi: 10.1016/j.ijnurstu.2019.05.015

# Resources

- PalliativeCaring_QLD.pdf
- Phone 1300 725537 - 24/7 doctor, nurse practitioner, pharmacist advice hotline
- Phone 1300 725527 - 24/7 nurse and allied health advice hotline
- SPaRTa (Specialist Palliative Care Rural Telehealth Service) for patients and their family
- ePPCS (Telehealth Paediatric Palliative Care Service)
- Ordering caring@home packages for in home support
- Palliative and end-of-life care Framework–last 12 months of life
- palliMEDS App to manage emergent or terminal symptoms




Link here

# MASS – Clinical Education – Education Recordings

## General interest

- Meeting the Assistive Technology, Continence and Pressure Management Needs of Bariatric Clients
- Assistive Equipment and People with Dementia

## Daily Living Aids and Mobility Aids

- The Ins and Outs of Pressure Redistribution Mattresses
- Emerging research in pressure redistribution support surfaces
- Mattress and mattress overlay cleaning, maintenance and faults

## Palliative Care

Palliative Care Equipment Program - update and case studies

Equipment for pressure injury prevention in palliative care

Electric adjustable bed set-up for palliative care

Continence management in palliative care

Assessing and prescribing beds and recliner / fallout chairs in the palliative care context

Assessment and Management of End-of-Life Skin Changes in the Palliative Population

Links to each recording are hyperlinked Click here to explore all MASS Education Recordings

# Resources for Carers

## Practical Care Videos

There are many new tasks that you may find you need to do to provide practical care for the person, particularly once they are unable to get out of bed. The Palliative Care Team at Sacred Heart have made these videos to help families provide practical care.

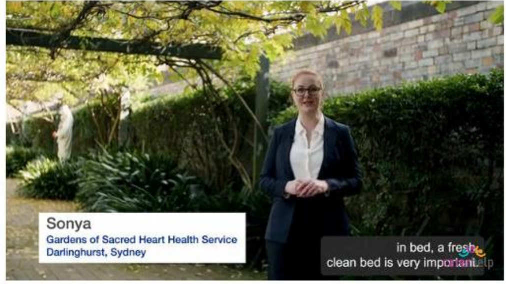
How to reposition someone safely in bed

WHAT YOU WILL NEED

- Change of clothing if needed
- Incontinence pad
- Bluey (A bluey is a plastic sheet with an absorbent layer on top)
- Gloves
- Plastic bag
- Moisturising cream

Moisturising cream.

How to change incontinence aid




How to change bedsheets

How to care for a urinary catheter

[Practical care videos - Resources]

# Continence

# Learning Objectives



- Continence and person-centred care
- Continence assessment for someone who is bedbound
- Evidence based prevention and management strategies:
  - Bowels
  - Bladder
  - Incontinence-associated dermatitis
- Recorded webinars on continence
- Demonstration of continence aids

# Continence and Person-centred Care

- Urinary incontinence is experienced by over 60% of UK palliative service users (Yates, 2019)
- Loss of body functions
- Distress and discomfort
- Loss of independence and dignity
- Fear of future losses
- Daily symptom management should include continence review and management
- Focus on the client and carer goals and QOL

Image generated by AI


Jackson, D. (2022). Incontinence in palliative care: assessment to promote dignity. *British Journal of Community Nursing*. 27(5), 242 - 251.

# Continence Assessment

# Continence Assessment

Image generated by AI

Does the disease impact the nerve pathways causing neurological urinary or bowel dysfunction?

Does the client have metastasis in the spinal cord, colon, rectum, peritoneum or local disease extension to bladder, prostate or urethra?

If the client has neurological impacts from disease progression it may impact on nerve pathways to pelvic floor, anal sphincter or detrusor muscle/urinary sphincters

# Key Nerve Pathways to consider

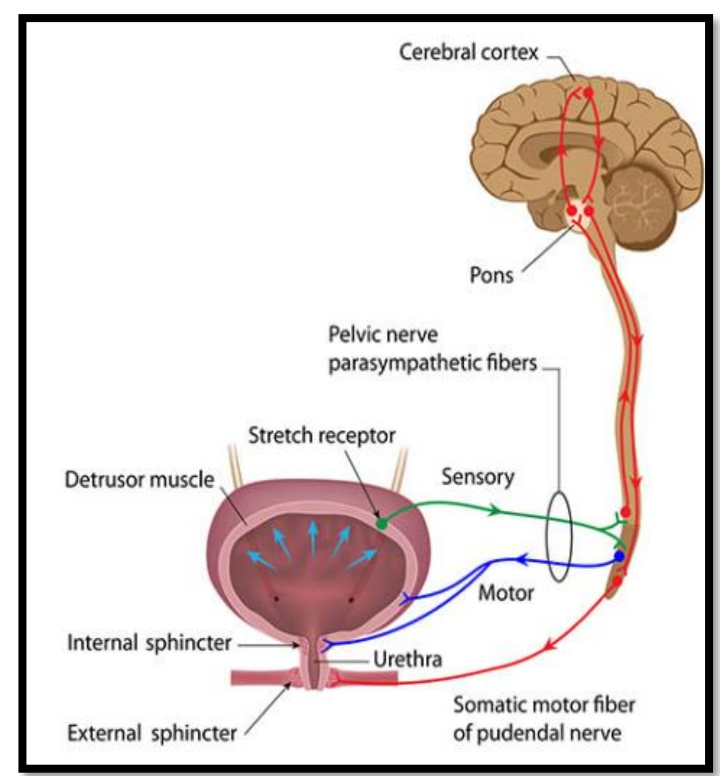
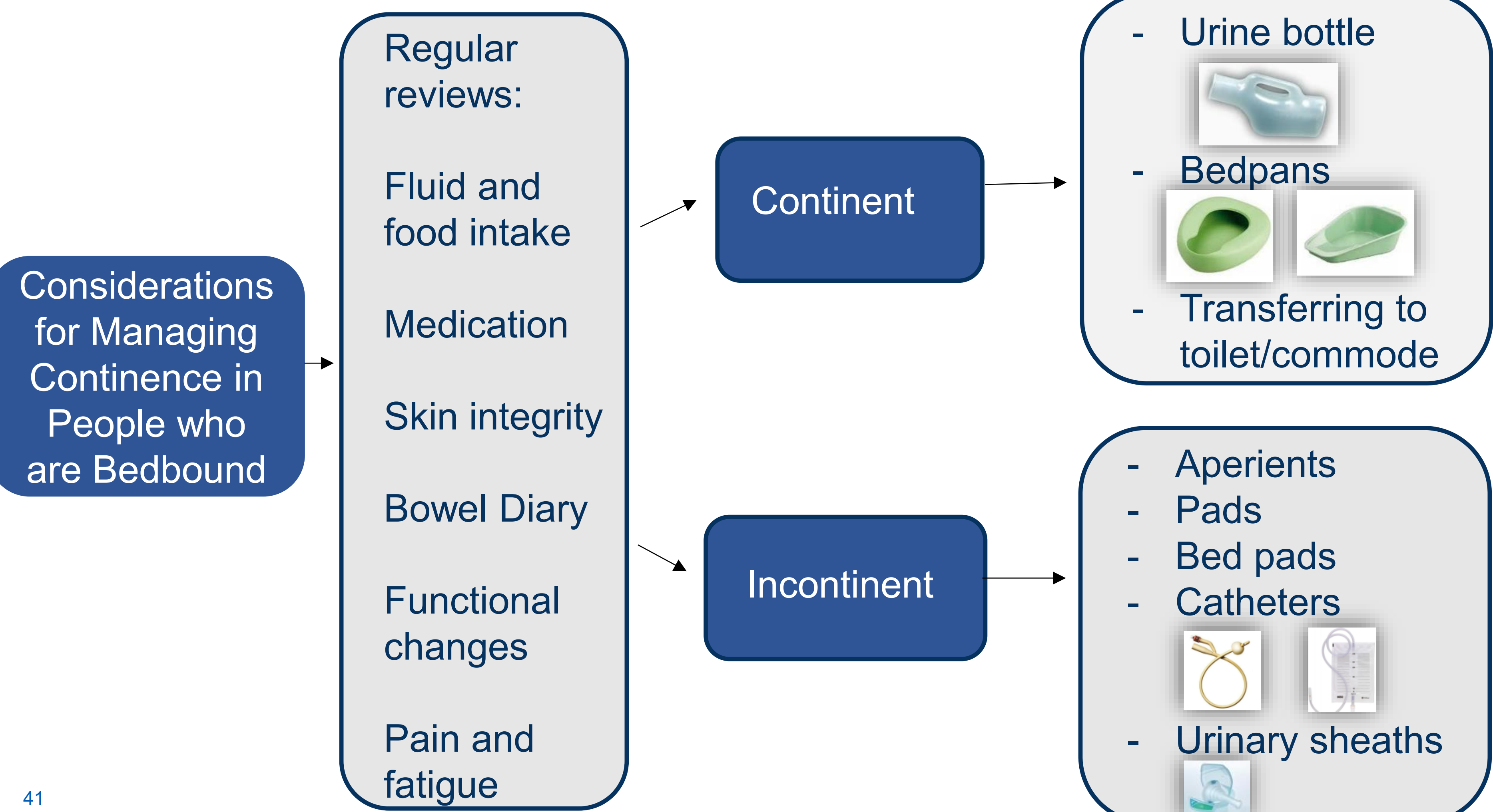



Image from Ausmed Neurogenic Bladder Management and Nursing Care

- **Parasympathetic Nerve (Pelvic Nerve S2-S4)** controls the contraction of the detrusor muscle to empty the bladder
- **Sympathetic Nerve (Hypogastric Nerve T11-L2)** relaxes the detrusor muscle to allow filling and contracts the internal sphincter to keep urine in
- **Somatic Nerve (Pudendal Nerve S2-S4)** provides voluntary control over the external sphincter allowing the conscious holding or release of urine
- **Spinal cord interruption** can break this connection resulting in a “reflex bladder” which is uncontrolled emptying or a “Flaccid bladder” so unable to contract and empty

# Management of Continence


Considerations for Managing Continence in People who are Bedbound
Regular reviews:
Fluid and food intake
Medication
Skin integrity
Bowel Diary
Functional changes
Pain and fatigue
Continent
Incontinent
- Urine bottle
- Bedpans
- Transferring to toilet/commode
- Aperients
- Pads
- Bed pads
- Catheters
- Urinary sheaths

# Difficulty walking or transferring to toilet

3-in-1 commode

Static [bedside] commode

Hoist

Consider:
- Pain
- Fatigue
- Carer strain
- Medical devices

Toilet surround

Over toilet aid

Mobile shower commode (MSC) ± pan

# Kathryn

- Divorced mother of three young children
- Terminal ovarian cancer with metastases
- Previous chemotherapy and pelvic radiation
- Alternating constipation and loose stools
- Heavy urinary incontinence
- In bed cares provided by sister

Image generated by AI

# Kathryn

- Are any of Kathryn's medications putting her at risk of UI or constipation?
- Can Kathryn still get out of bed with a hoist to manage bowel cares?
- Does Kathryn have current skin issues or at risk of skin issues from UI or FI?
- When is it appropriate to insert a urinary catheter?
- What are Kathryn's feelings around continence management?
- Is the carer able to manage Kathryn's continence care?

Image generated by AI

# Conservative Bowel Strategies

Review client's hydration

Review diet and fibre if appropriate

Maximise gastro colic reflex

Introduce osmotic agents if needed

Continence aids/faecal booster pads

Protect skin if loose stools

Introduce aperients to prevent constipation

Image generated by AI

# Loose stools

Image generated by AI

- Determine the cause of the loose stools e.g. radiation colitis, infection (clostridium difficile), pancreatic insufficiency, medication or overflow constipation
- If a new symptom of large and frequent loose stools, then a stool specimen may be required
- If overflow constipation is suspected, review for osmotic aperients e.g. Movicol

Palmer, S. J. (2019). Faecal Incontinence in Palliative Care and End-of-Life Care. *British Journal of Nursing. 24*(11), 528 - 533.

# Constipation

- Straining, abdominal discomfort or incomplete emptying
- 87% of terminally ill patients receiving Opioids report constipation
- If starting on Opioids add a stimulant laxative
- Suppository may be required for clients who are bedbound

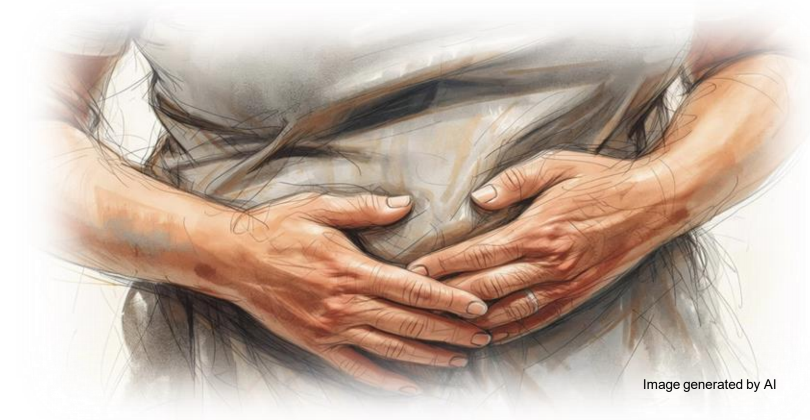


Image generated by AI

Boland, J.W. & Boland, E.G. (2022). Constipation and malignant bowel obstruction in palliative care. *Medicine. 50*(12), 775-779.

# Aperients to Soften or Quicken Bowel Movements

Laxatives

e.g.Movicol, Osmolax and Lactulose

*Action: 24 – 48 hours*

Stimulants

e.g. Coloxyl, Sennokot, Bisalax

*Action: 6 - 12 hours*

Suppositories

e,g. Glycerine, Durolax

*Promotes rapid evacuation 20 - 30 min*

Enemas

Microlax

*Promotes rapid evacuation 5 – 15 min*

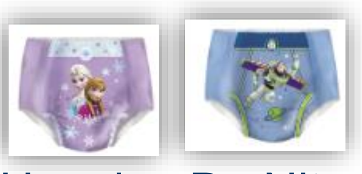
# Medications that Impact Bladder and Bowel

- **Antipsychotics** used to treat agitation, and nausea can cause urethral relaxation – UI
- **Benzodiazepines** used for delirium/agitation/anxiety can cause reduced urethral pressure and UI
- **Diuretics** – Furosemide causes rapid bladder filling leading to urinary urgency and UI
- **Opioids** inhibit the neural pathways which are responsible for bladder contraction risking acute urinary retention or bladder distention

Image from PallConsult: A practical handbook for health professionals

Pais, R. et.al. (2020). Bladder Care in Palliative Care in Palliative Care Inpatients: a Prospective Dual Site Cohort Study. *Palliative Medicine Reports. 1.1*, 251-258. http://online.liebertpub.com/doi/10.1089/pmr.2020.0060

# Pad Options



Huggies DryNites

MoliCare
Premium Mobile
Unisex 8 Drops

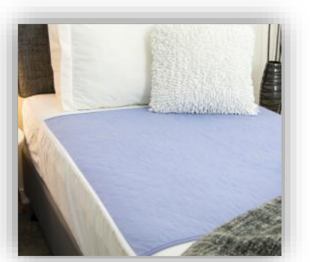
Tena Pants Maxi
Proskin

MoliCare
Premium
Elastic
All-in-One Pad

Fitright
Bariatric Brief
All-in-One Pad

Image from
Tena website

Abena Pants
Special



Conni Bed pad

Conni Chair pad

# Aids for Men

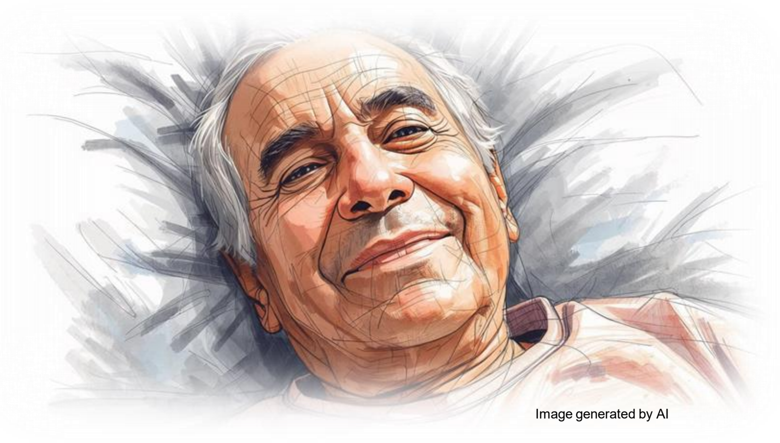


Image generated by AI

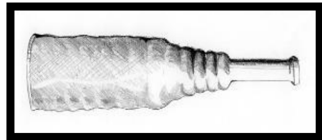
Urine bottle

Molicare elastic
with velro sides

Urinary sheaths

# Urinary Sheaths: Client Assessment

- Client and Carer require information on the sheath and how to use it
- Consent must be given prior to measuring a client for size of sheath
- Measure client using the Sheath measurement tool
- Review length of penis to decide which style of sheath ie Standard length or short length
- Use tool to measure mid shaft for size of sheath
- Choose smaller size sheath if in between



# Reasons for Catheterisation in Palliative Care

Image from Shutterstock

Urinary retention- no sensation to void

Patient comfort- pain related to change of aids or bedding

Psychological distress associated with incontinence- ease of care for bedbound patients

Severe urinary incontinence causing significant IAD



Pais, R. et.al. (2020). Bladder Care in Palliative Care in Palliative Care Inpatients: a Prospective Dual Site Cohort Study. *Palliative Medicine Reports. 1.1*, 251-258. http://online.liebertpub.com/doi/10.1089/pmr.2020.0060

# Purewick Urine Collection system

Not subsided through MASS

Image from Medisa

# Incontinence-Associated Dermatitis (IAD)

## IAD severity categorisation tool

| Clinical presentation | Severity of IAD | Signs** |
|---|---|---|
| Image ©3M 2014 | No redness and skin intact (at risk) | Skin is normal as compared to rest of body (no signs of IAD) |
| Image courtesy Joan Junkin | Category 1 - Red* but skin intact (mild) | Erythema<br>+/-oedema |
| Image ©3M 2014 moderate; Image courtesy Joan Junkin severe | Category 2 - Red* with skin breakdown (moderate-severe) | As above for Category 1<br>+/-vesicles/bullae/skin erosion<br>+/- denudation of skin<br>+/- skin infection |

* Or paler, darker, purple, dark red or yellow in patients with darker skin tones

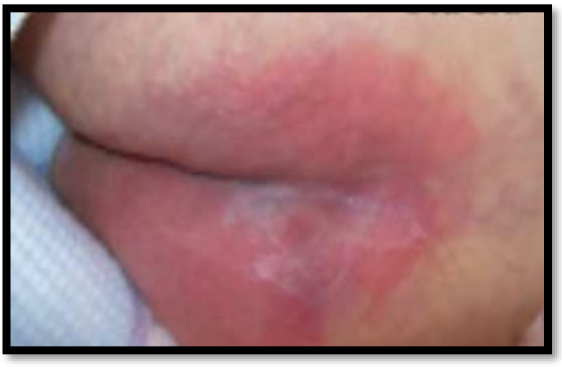
**If the patient is not incontinent, the condition is not IAD

| Parameter | IAD | Pressure ulcer |
|---|---|---|
| History | Urinary and/or faecal incontinence | Exposure to pressure/shear |
| Symptoms | Pain, burning, itching, tingling | Pain |
| Location | Affects perineum, perigenital area; buttocks; gluteal fold; medial and posterior aspects of upper thighs; lower back; may extend over bony prominence | Usually over a bony prominence or associated with location of a medical device |
| Shape/edges | Affected area is diffuse with poorly-defined edges/may be blotchy | Distinct edges or margins |
| Presentation/depth | Intact skin with erythema (blanchable or non-blanchable), with/without superficial, partial-thickness skin loss | Presentation varies from intact skin with non-blanchable erythema to full-thickness skin loss<br>Base of wound may contain non-viable tissue |
| Other | Secondary superficial skin infection (e.g. candidiasis) may be present | Secondary soft tissue infection may be present |



Beeckman, D. et.al. (2015). Incontinence-Associated Dermatitis: Moving Prevention Forward. Addressing evidence gaps for best practice. *Wounds International Best Practice Principles*,1 - 21. dd22237e07012637d4674b594501a692.pdf

# Risks for IAD



- Skin exposure to UI and FI
- Frequent loose stools
- Excess moisture
- Inappropriate pads/occlusive pads
- Immobility
- Poor skin condition
- Poor nutritional status and inability to perform personal hygiene.
- Cognitive impairment
- Obesity
- Diabetes
- Medications-antibiotics

*If a client is not incontinent it is not IAD*



Beeckman, D. et.al. (2015). Incontinence-Associated Dermatitis: Moving Prevention Forward. Addressing evidence gaps for best practice. *Wounds International Best Practice Principles*,1 - 21. dd22237e07012637d4674b594501a692.pdf

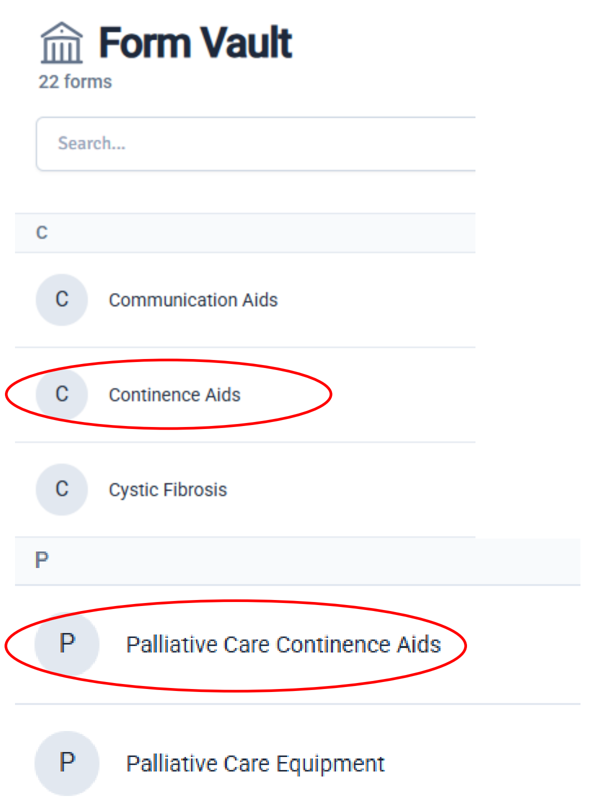
# Actions and Prevention of IAD

- Frequent skin inspections including skin folds (buttocks, perineum, upper thighs and lower back)
- Manage incontinence – correct product selection
- Remove layers – no bed protectors / just aids
- If bed pads needed just disposable high absorbency
- Correct pad size
- Implement skin care (cleanse, protect and restore)
- Review for secondary infections like Candida fungal infections

# Skin care

**BARRIER CREAMS / SPRAYS / APPLICATORS/ CLEANSERS** **WIPES**

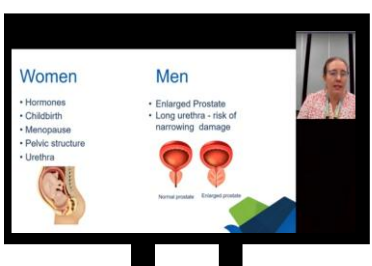
# Applying for Continence Aids through MASS




- Complex applicants through MASS or PCEP can be discussed with the clinical advisor for continence
- MASS Continence - Initial and three (3) yearly applications require an assessment
- PCEP Continence - after first MASS eApply application, if the client's needs change, re-orders of aids can be attended at any time through a phone order with team

MASS-eApply

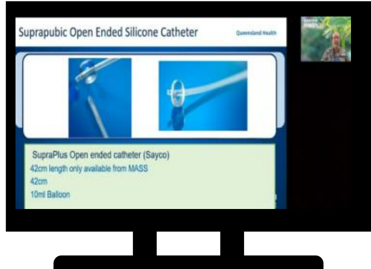
# MASS Recorded Webinars - Continence



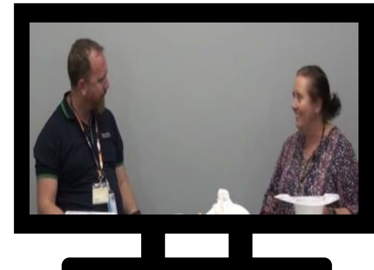

How to complete a continence assessment

Overview of Products in the new MASS Continence Standing Offer Arrangement (SOA)

Applying for continence aids using MASS-eApply, after recent upgrades to the system




An overview of catheters



Continence management in palliative care

Continence management strategies

Education Recordings | Queensland Health

# Certificate of Attendance

Complete the webinar feedback form to receive a certificate of attendance.

# Thank you!

MASS-Education@health.qld.gov.au

# Demonstration of Continence Aids