

## Patient experience with bedpans in acute care: a cross-sectional study

Heidrun Gattinger, Birgit Werner and Susi Saxer

**Aims and objectives.** To describe individual experiences of patients using the bedpan in an acute care setting.

**Background.** Patients describe the use of the bedpan often as uncomfortable and painful, and nurses mention difficulties using standard-sized bedpans for obese patients or removing a bedpan without soiling the bed. Although the bedpan is still regularly used in hospitals, there are few empirical studies that confirm these experiences.

**Design.** A descriptive quantitative research design.

**Methods.** A convenience sample of 78 patients was recruited, and data were collected using a standardised questionnaire (German version of the Bedpan Ongemak Schaal). Descriptive statistics were used to analyse frequency (scale A) and extent of inconvenient experiences (scale B). Internal consistency of the scales was tested using Cronbach's alpha.

**Results.** A major finding of the study was that most patients felt dependent on other persons and no autonomous movement was possible on the bedpan. Patients were frequently confronted with pain, inconvenient characteristics of the bedpan (e.g. coldness, hardness), uncomfortable positions and hygiene inconveniences (e.g. wet backside, fear that urination may miss the bedpan).

**Conclusion.** As the bedpan is still regularly used in acute care hospitals, innovations in bedpan models are necessary to address the problems. But there are also several courses of action nurses should consider when caring for patients who are dependent on the bedpan.

**Relevance for clinical practice.** The discomfort of the bedpan, the feeling of dependency and embarrassment could lead to undesirable patient reactions, such as avoidance of fluid intake or leaving the bed. If nurses know the reasons for this behaviour, they could meet these problems with empathetic understanding.

**Key words:** acute care, bedpan, cross-sectional study, dependency, embarrassment, nurses, nursing, patient experiences, toileting

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### Introduction

In hospitals, patients are temporarily confined to bed as a result of illness, injury or surgery, thereby necessitating the use of a bedpan. The bedpan has had a similar form for centuries and has been made of the same material for decades. Although in recent years, disposable bedpans have become more popular, the traditional metal or hard plastic

bedpan is still regularly used in acute care hospitals in countries like Switzerland, Austria and Germany. A 2009 survey investigated how often bedpans were needed in Swiss hospitals. Almost one-fifth of women and 10.8% of men had to use it for a certain amount of time during their stay. Men less frequently use the bedpan because urine bottles are an alternative for urination (Saxer *et al.* 2011). There are also alternatives for bedridden women,

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for example urine bottles for women or other forms of urinals. Depending on the health situation, these alternatives are used with varying frequency.

For stool excretion – an immensely greater burden than urinary excretion – bedridden women and men have to use the bedpan (Dettmer 2009). Stool excretion is a very intimate matter for which people frequently have their own rituals. A separate room with a door usually guarantees a person's privacy (Roper *et al.* 2002, Kellnhauser & Juchli 2004). If the intimate act of toileting has to take place in the presence of strangers, a loss of privacy and dignity may occur. To sit on the bedpan is one of the most embarrassing experiences a patient may have in hospital (Prentice 1995, Bauer 1996). Patients wish to be treated with dignity and respect, particularly during intimate care such as washing, dressing and toileting, which invariably invades one's privacy and can cause intense embarrassment (Woogara 2001). A conditional loss of privacy and dignity during hospital stay seems to be accepted by patients (Matiti & Trorey 2004, Malcolm 2005). However, they show a high privacy preference value with regard to toileting facilities (Bäck & Wikblad 1998, Enz & Mantovan 2008).

Furthermore, dependency on other persons in case of illness could lead to low self-esteem and loss of privacy (Lawler 2006, Huss & Krampe 2008). Patients in hospital are frequently in a vulnerable state. They experience uncertainty about their future and feel powerless concerning their situation (Ellefsen 2002). This loss of control alone would be enough to cause embarrassment. Additionally, to be dependent on another person with regard to toileting is experienced as humiliating (Bauer 1996, Borbasi 1996, Ellefsen 2002, Enz & Mantovan 2008). For these reasons, patients often avoid using the bedpan by reducing the amount of fluid intake. Some patients secretly leave their bed in order to go to the toilet (Bauer 1996, Dettmer 2009). This behaviour is dangerous and may have a negative impact on their health, especially if a sufficient quantity of fluid intake is necessary for therapeutic reasons. Moreover, a quick unaided walk to toilet facilities increases the risk of falling (Evans *et al.* 2001, Spoelstra *et al.* 2012). Apart from the disturbance of privacy and the feeling of dependency, some patients report physical pain caused by sitting too long on the bedpan in an inexpedient and unnatural position. Sensation of cold can be very uncomfortable (Prentice 1995, Arets *et al.* 1999, Cohen 2009). Other annoying matters of the physical structure of the bedpan are mentioned in the study by Cohen (2009): the noise caused by urinating into a metal bedpan and a narrow shape 'squeezing up the buttocks'. For these reasons, the use of the bedpan could be an influencing factor for the

nursing diagnosis of 'functional incontinence' (Doenges *et al.* 2002). Bedpan use is a risk factor for constipation, because some hospitalised patients try to avoid defaecation in the unfavourable environment (Richmond & Wright 2005, Su *et al.* 2009). Not only patients but also nurses report problems with bedpans. They often mention difficulties using standard-sized bedpans for obese patients or removing a bedpan without soiling the bed.

Although the use of bedpans is quite common in hospital settings, there are only a few empirical studies that confirm these experiences. The subject of this article is the individual experience of patients using the metal bedpan in an acute care setting. The aim is to develop new knowledge that may be useful for patients, nurses and other healthcare professionals. The leading questions are the following: What are the experiences of patients using the bedpan? How much discomfort does the bedpan cause? Whether there are differences in frequency and degree of inconvenient experiences with regard to gender, age and body constitution is also to be explored.

## Methods

A descriptive quantitative research design.

## Instrument

Data were collected by means of the German version of the Bedpan Ongemak Scaal© (BOS-D), a standardised questionnaire originally developed in Belgium (Everst *et al.* 1998). The authors conducted semistructured interviews with patients who had to use the bedpan, and identified six categories of inconvenience: (1) pain, (2) characteristics of the bedpan, (3) privacy and shame, (4) position on the bedpan, (5) dependency on other persons, and (6) hygiene. The BOS-D consists of 60 negatively worded items that refer to these categories, divided into two subscales. Subscale A assesses the frequency of experiencing inconvenience (e.g. 'the bedpan was too cold'). Subscale B addresses the extent of the inconvenience (e.g. 'I found it unpleasant that the bedpan was too cold'). The items are positioned pairwise on the questionnaire, and the choice of responses ranges from 1 (never – scale A/acceptable – scale B) to 5 (always – scale A/unacceptable – scale B). The Bedpan Ongemak Scaal© was tested in an explorative study with 87 patients in a Belgian hospital, with a reported Cronbach's alpha of 0.94 for the total scale (Everst *et al.* 1998).

The original Dutch version of the scale was translated into German following a parallel back-translation procedure. The BOS-D was validated with a small sample of

patients ( $n = 10$ ). The result shows that the questionnaire covers the most important issues (Karl & Panfil 2004).

### Sample

A non-probability sample with voluntary patient participation was recruited. Inclusion criteria were German-speaking women and men who had used the metal bedpan at least twice during their current hospital stay and had no problems with memory or cognition. Excluded were persons below 18 years of age and patients in terminal-stage illness.

### Data collection

All data were collected in a general hospital in the German-speaking part of Switzerland during a period of two months (December 2010–February 2011). Twenty-three wards participated in the study. The nursing manager of each ward identified eligible patients. They were informed about the study by the researcher and, in case of agreement (informed consent), had the choice of completing the questionnaire either on their own or by having the researcher read the items to them. No patient-identifying data were asked, and completed questionnaires were put in an envelope to assure patient anonymity.

### Ethics considerations

The research project was conducted according to the ethics principles of Swiss law and with the approval of the ethics commission in charge (EKSG 10/117). Patients were given verbal and written information about the study, its aim and the voluntary nature of participation. Participants signed an informed consent. To ensure confidentiality and anonymity, no names or other identifiers were used.

### Analyses

The software *SPSS* statistics, version 17 for Windows (*SPSS* Inc., Chicago, IL, USA) was used to analyse the data. Descriptive statistics (absolute frequencies and number of percentages) were used to analyse general characteristics of participants as well as frequency and extent of inconvenient experiences. Data from scale B (inconvenient experience) were not analysed if the patient answered the matched item from scale A (frequency of experience) with 'never'. The five response categories of scale A and scale B were summarised into three as follows: scale A: 'almost ever' and 'ever' become 'always', 'at times' and 'periodically' become 'sometimes' and 'never' remains 'never'; scale B: 'bad' and

'very bad' become 'unacceptable', 'hardly disturbing/unpleasant' and 'moderately disturbing/unpleasant' become 'tolerable' and 'not disturbing/unpleasant' become 'acceptable'. Thus, we had no normally distributed data, Pearson's chi-squared test and Fisher's exact test were used to analyse differences in proportions between groups (male – female;  $\leq 70$  years–  $>70$  years; underweight/normal weight – overweight/obese). Statistical significance was set to  $p < 0.05$  (two-tailed). Cronbach's alpha was used to assess the internal consistency of the subscales. The item-level statistics 'alpha if item deleted' was used to explore weak items. According to conventional rules, the alpha coefficient should at least exceed 0.70 (Kline 2000). By applying the 'alpha if item deleted' statistics, the alpha coefficient should not substantially be affected by the removal of any item (Field 2009).

## Results

### Participants

From a total of 111 eligible patients, 17 did not wish to take part in the study, four could not be contacted, and three were excluded because they used another type of bedpan than the one reviewed. Thus, data were obtained from 87 patients from different surgical and non-surgical wards. Surgical wards included orthopaedic and general surgical wards; non-surgical wards consisted of internal medicine, neurological and gynaecological wards. Forty-nine per cent of the included patients had surgery of a lower extremity, including knee and hip replacement or an amputation. Thirteen per cent had upper musculoskeletal problems or a spinal injury. Other diagnoses were lung and heart diseases (11%). Eight per cent were patients with cancer who had to use the bedpan because of a general poor state of health and weakness. Others had abdominal surgery (5%), problems during pregnancy (3%) or other problems (11%). Mean age was 67.2 years (SD, 14.7 years), and 71% were women. More than half of the participants had to use the bedpan over a period of more than three days (Table 1).

### Internal consistency reliability

Internal consistency reliability was assessed within the six categories of the BOS-D using Cronbach's alpha (Table 2). The internal consistency reliability for the subscales was between 0.40–0.72 (scale A) and between 0.60–0.80 (scale B). Seven items with weak internal consistency were found after reviewing the item-level data (alpha if item deleted).

**Table 1** Background characteristics of patients included in the study

Variables	<i>n</i>	Percentage (%)
Sex		
Male	25	29%
Female	62	71%
Age (mean ± SD)	67.18 ± 14.718	30–95*
Body mass index (kg/m <sup>2</sup> )		
Underweight/normal weight (BMI ≤ 24.99)	36	42%
Overweight/Obese (BMI ≥ 25)	49	58%
Patients included from		
Surgical wards	54	67%
Non-surgical wards	27	33%
Diagnosis		
Surgery of a lower extremity	37	49%
Upper musculoskeletal diseases	10	13%
Heart or lung disease	8	11%
Malignant disease	6	8%
Abdominal surgery	5	4%
Problems during pregnancy	2	3%
Others	8	11%
Patients who used the bedpan		
1–3 days	30	38%
>3 days	49	62%

\*Represents range.

The psychometrically weak items were the following: item 16a 'independent movement impossible', which increased Cronbach's alpha of the category 'position on the bedpan – scale A' to 0.57; item 21a 'bedpan was not deep enough', which increased Cronbach's alpha of the category 'characteristics of the bedpan – scale A' to 0.56; item 21b 'felt unpleasant if bedpan was not deep enough', which increased Cronbach's alpha of the category 'characteristic of the bedpan – scale B' to 0.64; item 25a 'bedpan removed by another nurse', which increased Cronbach's alpha in the category

'dependency on other persons – scale A' to 0.51; item 26b 'felt unpleasant if it took a long time until bedpan was removed', which increased Cronbach's alpha in the category 'dependency on other persons – scale B' to 0.65; item 28a 'bedpan was not clean', which increased Cronbach's alpha of the category 'hygiene – scale A' to 0.54; and item 28b 'felt unpleasant if bedpan was not clean', which increased Cronbach's alpha of the category 'hygiene – scale B' to 0.58.

### Descriptive findings of the study

Analysis of the results is structured according to categories developed by the author of the questionnaire: pain, bedpan characteristics, privacy and shame, position on the bedpan, dependency on other persons and hygiene (Everst *et al.* 1998).

Figure 1 presents results for all items concerning frequency of experiences. Figure 2 shows results for all items concerning the degree of inconvenience. The following description of results is limited to the frequency of experiences that occurred 'always' and 'sometimes' and to inconvenient experiences that were assessed as 'unacceptable'.

#### Pain

Pain is mainly caused by sitting on the bedpan for an extended period of time and was experienced by 66% ( $n = 57$ ) of patients. Another cause of pain was lying in a supine position, which was mentioned by 48% ( $n = 40$ ). Of those patients who reported pain resulting either from sitting on the bedpan or from lying in a supine position, more than half (53%,  $n = 30$ ; 60%,  $n = 24$ ) assessed this experience as unacceptable. Forty-one per cent ( $n = 35$ ) of respondents described pain as a result of their physical constitution. This amounted to an unacceptable situation for 41% ( $n = 14$ ) and was mentioned significantly more frequently by normal-weight or underweight patients than by overweight patients ( $p = 0.017$ ). However, a majority did not have coccyx pain or back pain. If coccyx and back pain occurred, it was assessed as unacceptable by 45% ( $n = 14$ ) and 42% ( $n = 10$ ), respectively.

**Table 2** BOS-D: categories, no. of items and Cronbach's alpha coefficient of scales A and B

Categories of the BOS-D	No. of items	$\alpha$ coefficient scale A	$\alpha$ coefficient scale B
Pain	5	0.72	0.74
Characteristics of the bedpan	5	0.48	0.57
Privacy and shame	5	0.72	0.80
Position on the bedpan	6	0.49	0.73
Dependency on other persons	5	0.40	0.61
Hygiene	4	0.50	0.57

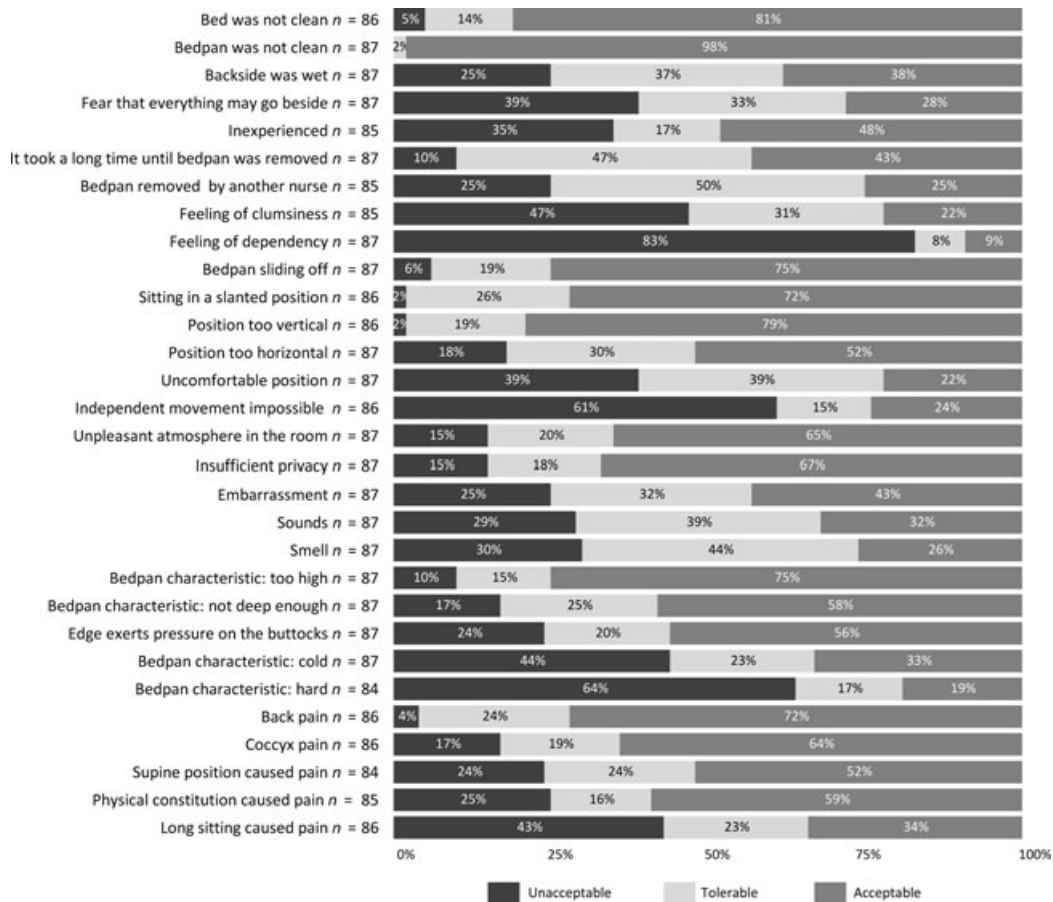


Figure 1 Frequency of patients' experiences.

*Characteristics of the bedpan*

The two most frequently experienced negative characteristics of the bedpan are its hardness (81%, *n* = 68) and coldness (67%, *n* = 58), with the latter being the more painful parameter (unacceptable for 41%, *n* = 24). Forty-four per cent (*n* = 38) of patients reported that the edge of the bedpan exerts pressure on the buttocks, which was an unacceptable experience for 71% (*n* = 27). The bedpan was described as not deep enough (42%, *n* = 37) rather than too high (25%, *n* = 22). If it was experienced as 'not deep enough', 58% (*n* = 21) of patients felt considerable unpleasantness. Forty-one per cent (*n* = 9) reported the bedpan being 'too high' as unacceptable.

*Privacy and shame*

For more than one-half of the patients (57%, *n* = 50), the use of the bedpan was embarrassing. Most of them (62%, *n* = 31) felt considerable unpleasantness; especially, smell and sounds experienced by 74% (*n* = 64) and 68% (*n* = 59) were assessed as unacceptable by 55% (*n* = 34) and 43% (*n* = 25), respectively. The majority of patients did not

mention a lack of privacy (67%, *n* = 58) or an unpleasant atmosphere (65%, *n* = 57) as a problem, but when that was mentioned, 45% (*n* = 13) and 47% (*n* = 14), respectively, assessed the situation as unacceptable.

*Position on the bedpan*

The majority of participants reported that they had to sit in an uncomfortable position on the bedpan (78%, *n* = 68) and that they were not able to move independently in this position (76%, *n* = 65). These experiences were assessed as unacceptable by 53% (*n* = 36) and 40% (*n* = 25), respectively. For half of the patients, the sitting position was too horizontal, which was unpleasant for 48% (*n* = 20) of patients. By contrast, most of the participants did not have problems with sitting too vertically nor had the feeling of sitting in a slanted position. But if patients experienced this, 28% (*n* = 5) and 46% (*n* = 11), respectively, assessed it as unacceptable. Most patients did not have the feeling of sliding off the bedpan, but if this occurred, it was assessed as unacceptable by 55% (*n* = 12).

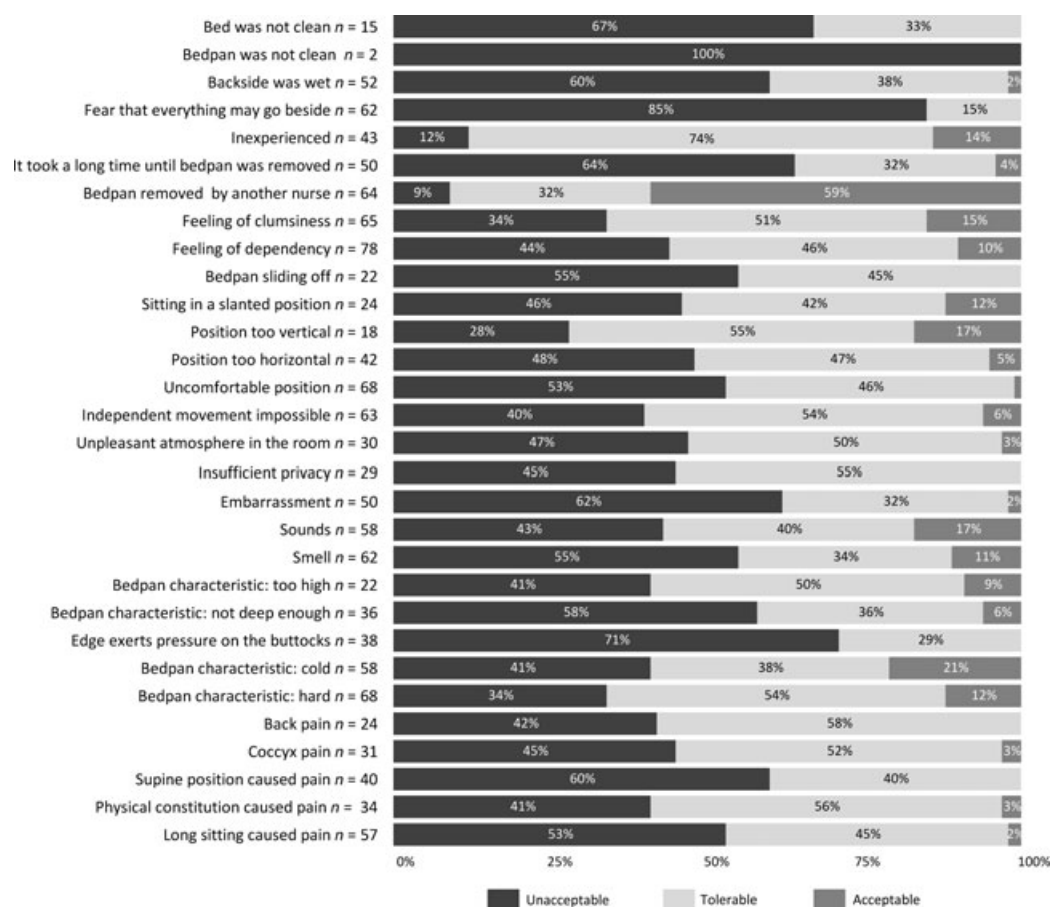


Figure 2 Degree of patient inconvenience.

### Dependency on other persons

A substantial part of the participants (91%,  $n = 79$ ) felt dependent on other persons, and 78% ( $n = 66$ ) had a feeling of clumsiness when sitting on the bedpan. These experiences were assessed as unacceptable by 44% ( $n = 34$ ) and 34% ( $n = 22$ ), respectively. The feeling of inexperience, mentioned by 52% ( $n = 44$ ), was an inconsiderable problem for the majority and was assessed as unacceptable by only 12% ( $n = 5$ ) of patients. Three-quarters of the participants reported that another nurse removed the bedpan, but this was mentioned as unacceptable by only 9% ( $n = 6$ ). However, 57% ( $n = 50$ ) had to wait for a long time until the bedpan was removed and more than half of them (64%,  $n = 32$ ) assessed this as unacceptable.

### Hygiene

Seventy-two per cent ( $n = 63$ ) of patients were afraid that their urine might miss the bedpan, and more than half of them experienced that their backside was wet. These two aspects were assessed as unacceptable by 85% ( $n = 53$ )

and 60% ( $n = 31$ ), respectively, and were reported more frequently by women than by men ( $p = 0.002$ ;  $p = 0.013$ ). The bedpan and the bed were experienced as clean and dry by the majority, but if this was not the case, patients evaluated this as an unpleasant and unacceptable experience.

### Discussion

This study examined patients' experience with bedpans during their hospital stay. Most patients reported that they felt dependent on other persons and that no autonomous movement was possible, amounting to an unpleasant situation for almost half of them. Independence is a high value for patients with regard to toileting (Bauer 1996, Enz & Mantovan 2008), so this seems to be a significant aspect of care of which nurses should be aware. Ellefsen (2002) stresses that dependency is acceptable if it is regarded as 'natural', for example if a patient is ill or has health deficits. But it is unacceptable in long-term situations and if patients

experience restrictions in social relationships due to reduced autonomy. Bauer (1996) argues that dependency increases during a long-term hospital stay and becomes unacceptable due to worries about loss of control and fear of becoming a burden for others. Patients' perception of nursing quality largely depends on the nurses' ability to meet patients' needs (Borbasi 1996, Meade *et al.* 2006). Immobile patients who require toileting assistance usually communicate their needs using the call light. This is the primary reason for patient-initiated call lights (Tzeng 2010). Scheduled bedside rounds could be a way to offer toileting assistance routinely and diminish the feeling of dependency (Meade *et al.* 2006).

Other frequently mentioned aspects were the inconvenient characteristics of the bedpan, including its hardness and coldness, as well as the feeling that its edge exerts pressure on the buttocks. These findings suggest that innovations in bedpan models are necessary. A bedpan producer from Germany addressed these issues by producing a model with an enlarged seat-engaging surface that could allow more comfort. This is supported by reports of hospitals and patients, but an empirical analysis of the product is still missing.

In the category of privacy, the most embarrassing experience for patients was the occurrence of sounds and smells. This is similar to the results of Bauer's study (1996): being observed during the act of toileting and the fact that another person might smell something were mentioned as considerable burdens. Curtains between beds in shared hospital rooms do not ensure the same degree of privacy as solid walls. Although curtains do not provide full auditory privacy, visual privacy could be satisfactorily protected (Barlas 2001, Douglas & Douglas 2004, Malcolm 2005). Furthermore, a smaller group of patients in this study mentioned insufficient privacy or an unpleasant atmosphere in the room. This was unexpected, but there are some possible explanations for this. First, the concept of privacy is influenced by many factors and involves subjective perceptions (Leino-Kilpi *et al.* 2001). The individual perception of privacy is different for each patient; this different perception is, however, not considered in this study. Second, the environmental conditions in a hospital setting (shared patient rooms) could lead to a conditional limited acceptance of reduced privacy as reflected in Bäck & Wikblad's study (1998). Malcolm (2005) argued that social factors such as power imbalance between patients and health professionals and compliance expectations in the hospital setting may increase patients' willingness to accept less privacy. Nevertheless, it is very important to protect patients' privacy during toileting. This includes adequate explanations before all

procedures and asking for patient's permission to enter his/her private space (Bauer 1996).

Most patients reported that they had to sit in an uncomfortable position and, additionally, that the position was too horizontal. Nurses should also be aware of the fact that a supine position can cause pain. A lumbar support with a pillow could help to avoid this. Pillows positioned under the legs may enable patients to use the bedpan with less assistance from nurses and without lifting (Broad 1982, Fourie *et al.* 1992).

The fear of missing the bedpan while urinating and the feeling of wetness were prevalent among the patients. Due to the fact that men can use the urine bottle for urination, this problem mainly affects women. The use of special bedpan models for women and a suitable position on it could diminish these discomforts. Other urinal systems could be an alternative to the bedpan for some women.

## Conclusion

The purpose of the current study was to assess the situation of patients who had to use a bedpan in an acute care setting. The findings suggest that these patients are frequently confronted with pain, inconvenient characteristics of the bedpan (e.g. coldness, hardness), uncomfortable positions, hygiene inconveniences (e.g. wet backside, fear that urination may miss the bedpan), dependence on other persons and violated privacy. As the bedpan is still regularly used in acute care hospitals, innovations in bedpan models are necessary to address these problems. Additionally, there are also several courses of action nurses should consider when caring for patients who are dependent on the bedpan:

- Minimising the time of sitting on a bedpan.
- Supporting the lumbar region with a pillow, if patients are not allowed to sit in a vertical position on the bedpan.
- Using other bedpan models or applying a soft toilet overlay on the bedpan for cachectic patients.
- Warming up metal bedpans before using.
- Using curtains to protect patients' visual privacy.
- Asking other mobile patients to leave the room while a patient is using the bedpan.
- Checking the patient's position on the bedpan to avoid pain and inconvenience.
- Helping patients with a pillow under the legs to lift themselves on the bedpan more easily.
- Making sure that there is an adequate supply of toilet paper within reach.
- Responding immediately to a patients' call to minimise feelings of dependence.

- Offering a wet wipe afterwards.
- Opening a window or offering an air spray after using the bedpan.

## Limitation

The current study is limited by the use of a convenience sample and a small sample size. Thus, generalisability of the findings may not be truly representative of the general population. Nevertheless, the findings give some important details regarding the care of patients who have to use a bedpan. A further limitation of the study is the weak internal consistency of the subscales. Four subscales reached an alpha coefficient between 0.40–0.50, and three others reached an alpha coefficient between 0.57–0.61. Thus, all of these values were deemed unacceptable according to the criterion of 0.70. Nevertheless, all items of the BOS-D seem to be important for assessing negative experiences a patient may have with a bedpan. A concept analysis could clarify the concept of 'inconvenience of the bedpan' and reveal whether the two subscales of the BOS-D are suitable for evaluating the discomfort of the bedpan. Given that there are some speech differences between standard German and Swiss German, changes in wording are recommended for further application of the BOS-D in the German-speaking part of Switzerland. Additional investigations to assess the questionnaire's validity and reliability should be undertaken.

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## Relevance for clinical practice

Supporting bedridden patients with toileting procedures is one of the daily activities of the nurses. The discomfort of the bedpan, the feeling of dependency and embarrassment could lead to undesirable patient reactions, such as avoidance of fluid intake or leaving the bed. If nurses know the reasons for this behaviour, they could meet these problems with empathetic understanding and support measures.

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## Contributions

Study design: HG, SS; data collection and analysis: HG, BW, SS and manuscript preparation: HG, BW, SS.

## Conflicts of interest

No conflict of interest.



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