Contexts	Resources	Outcomes
• Nihilism – staff believe FI is inevitable with dementia • GP cooperation • Culture • Type of FI • Medication • Mobility/dexterity • Dementia/cognitive function • Resident's history • Authority for decisions • Inclusion in training planning • Empathy • Positive work environment • Stable workforce • Communication • Shared documentation • Family report • Staff observation • Interpretation of safeguarding policy	• Policy guidance • Support of the regulator • Provider policy • PCC approach • Adequate workforce • Time to care (e.g. toileting regimes) • Time to reflect and review • Continence specialist • Coaching/mentoring • Champions • Specialist advice/expertise • Evidence based assessment protocols • En-suite bathrooms • 'Dementia friendly' toilet facilities (signage, contrasting colours, floor types etc) • Suitable clothing • Pad supply • Suitable pads • Prompting regimes	**RESIDENT OUTCOMES** • Continence • Recognition/use of toilet • Minimisation of leakage • Skin integrity • Comfort • Minimisation of distress • Dignity **STAFF OUTCOMES** • Increased knowledge • Confidence • Work satisfaction **ORGANISATION OUTCOMES** • Cost • Resource use • Reduced use of health care services • Reputation

Taking contexts, resources and outcomes from our 'theory' diagram (note: no responses), starting to think what a narrative mid-range theory might look like…

Assessment tools for FI must convey that continence is achievable for people with dementia (normalisation) and staff need a certain level understanding of PCC and causes of FI (knowledge) along with the time to implement the care plan within normal practice. Ongoing access to a continence specialist and or mentor/coach

new C M(*response/resource*)O table

An example...

	Title	Year	Mechanism (Resource)	Context	Mechanism (Response)	Outcome
Stakeholder interviews	Care Home mangers	2014	Incentives/sanctions applied	Time consuming for GPs to visit CHs	GP cooperation	More frequent GP visits, better monitoring of residents' health
	Care Assistants			Type of FI	Address polypharmacy & other physiological factors affecting faecal continence	Comfort/continence
	Geriatricians		Medication review Resident's history/Family report			
	Care Home providers		Toilets are clearly labelled (picture not words)	Dementia/cognitive & physical function	Recognition & use of toilet	More voids in the toilet
	Resident representatives		Residents clothing is easy to take on and off (Velcro rather than zips etc.)	There is financial resource to purchase adapted clothing/ adapt facilities	Residents with the cognitive & physical ability are able to manage their own clothing to go to the toilet	Dignity/independence/ comfort/continence
			Pads	It is difficult to access pads		Most residents are in pads
			Continence service provides pads to those assessed as 'incontinent'	Culture/Nihilism – staff believe FI is inevitable with dementia	Residents are assessed immediately on arrival and assessment leans towards 'incontinent' to ensure pad supply	Containment of faeces in pads, skin damage, discomfort, distress
			Shared documentation Time to care			

Mid-range theory

Interventions to reduce FI in people with dementia living in care homes need to establish a common understanding of the potential for recovery, reduction and management of FI e.g. through training (PCC & FI knowledge), support... supported by structured assessment (including DRE where appropriate) and access to clinicians e.g. GP, geriatrician or continence specialist to develop interventions that reflect the degree of cognitive and physical capacity of the resident (personalised care plans), e.g. prompted voiding, nutrition, hydration, exercise, appropriate medication, appropriate pads that can be introduced as part of the everyday work pattern of the care home e.g. care home regimes incorporate time to assess, prevent and 'toilet' and allow for adapted environment with ongoing teaching, review and feedback for staff of how to achieve good FI care.

Mid-range theory v2

Interventions to reduce and manage well FI in people with dementia living in care homes need to establish a common understanding of the potential for recovery, reduction and management of FI e.g. through training (PCC & FI knowledge), support... supported by structured assessment (including DRE where appropriate) and access to clinicians e.g. GP, geriatrician or continence specialist with adequate staff ratios and toilet facilities to develop interventions that reflect the degree of cognitive and physical capacity of the resident (personalised care plans), e.g. prompted voiding, nutrition, hydration, exercise, appropriate medication, appropriate pads that can be introduced as part of the everyday work pattern of the care home e.g. care home regimes incorporate time to assess, prevent and 'toilet' and allow for adapted environment with ongoing teaching, review and feedback for staff of how to achieve good FI care.

Care staff, clinicians and managers are constantly negotiating the trade-offs between different resident, care home and staff outcomes

Mid-range theory v2outcomes

Outcomes indicative of reduced and well managed FI:

Resident

- Less distress (dependent continence and managed incontinence)
- Comfortable (dependent continence and managed incontinence)
- They and their family feel treated with dignity – feel loved and cared for and respected (dependent continence and managed incontinence)
- Able to use toilet with support (dependent continence)
- Good skin integrity (managed incontinence)
- Reduced leakage or soiled clothing/bedding (dependent continence and managed incontinence)

Staff

- Confident to manage incontinence and support dependent continence and believe continence is possible
- Feel satisfied in their work
- Have greater knowledge of causes and treatment/management of FI

Care Home

- Cost
- Saving staff time/using staff time better
- Reputation – home does not 'smell'
- Reputation – families feel their loved one is being well cared for