

## Original Article

## Preferences for Continence Care Experienced at End of Life: A Qualitative Study



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**Abstract**

**Context.** Functional dependence at end of life often leaves individuals requiring help for personal care, including maintaining continence. Current continence guidelines offer little direction for end of life continence care, and little is known of the perspectives of people receiving palliative care.

**Objectives.** The aim of the study was to examine the continence care preferences of people receiving palliative care to understand what approaches to care and what goals of care are important to them.

**Methods.** This is a qualitative descriptive exploratory study with data gathered in individual interviews using a semi-structured interview guide. Participants were receiving bladder and/or bowel care on either tertiary or hospice palliative care units.

**Results.** Fourteen Canadian patients (seven female, seven male), six from tertiary and eight from hospice palliative care units, were recruited. From the analysis, three themes were identified: loss of control, finding a way to manage, and caregivers can help and can hinder. Dignity was often lost as a result of having to receive continence care, with most participants following staff recommendations for management approaches as the easiest way. Patients did not recall being asked about their bladder and bowel preferences.

**Conclusions.** As patients approached end of life they were willing to give up dignity if it was required to address symptoms causing them more distress, like pain. Health care professionals and family have an important role in social interactions around continence care. Health care professionals should incorporate patient preferences as best they can and explain the options when treating incontinence at end of life. *J Pain Symptom Manage* 2019;57:1099–1105. © 2019 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

**Key Words**

Urinary incontinence, fecal incontinence, palliative care, patient preference

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**Background**

Functional dependence at end of life often leaves individuals requiring help for personal care, including continence needs. Urinary incontinence, constipation, and fecal incontinence are common at the end of life, occurring in up to 77% of older patients with cancer receiving palliative care.<sup>1</sup> High rates of loss of continence are associated with functional and cognitive decline as well as decreased quality of life.<sup>2–4</sup> Compared with hospital patients, the burden of incontinence for nursing home residents and those dying in

their own home may surpass that of pain.<sup>5</sup> Continence is also central to the preservation of individual dignity: of 213 palliative patients who were asked to rate their sense of dignity on a seven-point scale, those who indicated that “loss of dignity was a significant concern” were statistically significantly more likely to have difficulty with bowel functioning and heightened dependence.<sup>6</sup>

Little has been written about continence care at end of life. A review of textbooks and articles identified a “common sense” approach to continence care rather

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than evidence-based approach.<sup>7</sup> The applicability of national and international continence guidelines to end-of-life care is limited, as they are primarily aimed at treatment and cure.<sup>8</sup> Recent end-of-life guidance states that management should focus on minimizing the impact of symptoms to maintain quality of life in accordance with the patient's values and preferences.<sup>9</sup> Although there has been some focus on end-of-life continence care, there remains a paucity of evidence. What does exist suggests that cancer ward nurses may lack the skills and knowledge for effective bladder and bowel care for patients with cord compression secondary to metastatic disease.<sup>10</sup> Continence care at end of life frequently involves the use of indwelling urethral catheters without clear indication for continued use.<sup>11,12</sup> There is little documentation of patients' home bowel care management and individual preferences<sup>13</sup>; one study reported 23 of 100 participants were asked about their home bowel care, with only two asked at hospice admission.<sup>14</sup> Evidence suggests urinary incontinence care preferences of end-of-life patients differ from their practitioners and surrogate decision-makers.<sup>15</sup> This is problematic as the effectiveness of care is reduced when patient preferences are not followed.<sup>16</sup>

Given the paucity of evidence on end-of-life continence care, the aim of the study was to examine the continence care preferences of people receiving palliative care to understand what approaches to care and what care goals were important to them.

## Method

### Study Design

This study used a qualitative, descriptive, exploratory approach with individual semistructured interviews. Qualitative description, as described by Sandelowski,<sup>17,18</sup> is a form of naturalist inquiry involving interpretation that remains close to the data as given. The COREQ checklist (Appendix A) was used to guide reporting of the study.<sup>19</sup> The research team included experts in continence (K. H. and A. W.) and palliative care (R. F.).

### Participants

Purposive sampling was used to aid with recruiting adult patients in a tertiary palliative care unit and hospice palliative care unit<sup>20</sup> who were receiving any continence care (assistance with toileting, changing pads, etc.). Staff and physicians on the participating units were informed of the study at regular meetings. Nurses and physicians screened and referred potential participants, identifying those able to consent and the ability to complete a 30- to 45-minute interview with their professional judgment. Potential participants were provided

with study information by a researcher. All participants provided informed, written consent to participate. A single individual face-to-face interview was then scheduled and completed. Interviews were stopped if participants experienced significant distress or discomfort discussing their continence care.

### Data Collection

Interviews occurred from July 5 to October 12, 2017, and included a brief demographic data sheet that was completed before the interviews. Interviews were guided by a semistructured interview guide (Appendix B) focused on continence care and care approach preferences of participants. The first two interviews were conducted by K. H. (female, nurse researcher) and N. S. (male, undergraduate research student), with N. S. completing the remaining interviews once interview skills were established. Neither researcher had prior or existing relationships with participants. Interviews were digitally recorded and transcribed verbatim. Participant numbers were assigned as pseudonyms, and all identifying data were removed at the transcription stage. Interviews took place in private patient rooms or in a private area on the unit. Field notes were recorded after interview to document observations. All research material was kept in locked file cabinets in the researcher team's office to ensure identifying material was not lost and confidentiality was maintained. Interviews continued until data saturation was reached (no new codes were identified).

### Analysis

A conventional content analysis approach<sup>21</sup> was used. Analysis was conducted throughout the data collection period. Starting with the first interview, text of transcribed interviews was coded by two researchers (K. H. and N. S.) independently. Words, phrases, sentences, and paragraphs were manually coded to capture key concepts and units of meaning.<sup>22</sup> After the first two interviews, results were compared and discussed to construct the initial coding scheme and develop initial definitions for the codes and a coding framework. Subsequent interview transcripts resulted in additional data for existing codes and the addition of new codes. To ensure trustworthiness, a third researcher (A. W.) used the coding scheme to independently code two transcripts; additional codes identified were incorporated into the coding framework after team discussion. Codes were organized into clusters, then categories, and subsequently interpreted into themes. Field notes of observations recorded after interviews were used during the analysis to inform and remind the researchers about the care context and used to support decision-making during coding and the identification of categories and themes.

### Ethical Approval

This study was approved by the University of Alberta Health Ethics Review Board (Pro00072255).

### Results

Data saturation was reached after conducting interviews with 14 participants (7 males and 7 females; mean age 73 years). Further description of participants is in Table 1. The shortest interview was 4 minutes, and the longest, 36 minutes with a mean length of 14 minutes. Interview length was affected by the patient's symptom control at the time of the interview and individual tolerance. Participants had a variety of bladder and/or bowel issues, with 10 participants identifying their illness (primarily cancer) as the reason for their incontinence. Their mean length of stay before the interview was 25 days. After analysis was complete, 34 codes were identified, which collapsed into seven categories from which three themes were identified: 1) loss of control, 2) finding a way to manage, and 3) caregivers can help and can hinder (Table 2).

### Loss of Control

This theme reflected the participant's feelings of reduced control over their bladder and bowel, as well as the loss of their overall state of health and quality of life.

Participants described loss of control over their bladder and bowel as an uncomfortable sense that prevented urination or defecation from either starting or stopping. Participants described difficulties with mobility, ranging from needing assistance to get to a washroom to being bedridden. Even if bowel control

was retained, not being able to not get out of bed hindered participant ability to have a bowel movement independently. The ability to retain greater control over these bodily functions was important not only in being able to remain clean but also to avoid humiliation. The desire to recover control was described as freedom from having to wear absorbent products, which were equated to infant diapers, or at to at least be able to exercise choice in when and where elimination occurred:

I would like to not have to wear diapers or if I wear a diaper that I would have enough time and leisure to find a place to empty (C11).

Loss of bladder and bowel control was linked to discomfort, bother, and sometimes pain. At times, an intervention to contain urine, such as an indwelling urinary catheter, was perceived as painful and uncomfortable. Participants without catheters said they would not want one because of the potential discomfort and pain. Having a catheter was described as giving a feeling of having to urinate all the time or removal and insertion as a miserable experience. Keeping pain under control was most important to participants, and they described continence care sometimes making it worse. Being incontinent and having to receive continence care could be a part of the overall pain experience:

...when you are hurting everything hurts. Like [my buttock] is pretty red and ... down there and I'm thinking holy, I don't want to have to take [my pad] off, oh my god they are going to hurt. (C10)

Being incontinent was a challenge to dignity. Participants reported being embarrassed to tell their family about incontinence and even described declining

Table 1

Participant Characteristics

Participant	Site	Age (yrs) /Sex	Length of Stay on Unit (days)	Reason for Admission	Was Illness the Cause of Bladder/Bowel Dysfunction?	Bladder and/or Bowel Dysfunction
C1	1	67/male	12	Cancer (unspecified)	Yes	Urinary incontinence
C2	1	68/female	56	Breast cancer	No	Double incontinence
C3	2	85/male	49	Prostate cancer	No	Urinary retention
C4	2	70/female	10	Breast cancer	Yes	Double incontinence
C5	2	63/male	55	Stroke	Yes	Constipation
C6	2	81/female	45	Heart disease, kidney disease, and renal failure	No	Fecal incontinence
C7	2	66/female	41	Lung cancer	Yes	Fecal incontinence
C8	1	74/female	10	Ileostomy complications	Yes	Double incontinence
C9	2	74/male	5	Brain cancer	No	Urinary incontinence
C10	1	56/female	6	Pancreatic cancer	Yes	Double incontinence
C11	1	87/male	13	Rectal and liver cancer	Yes	Constipation
C12	1	82/male	14	Prostate cancer	Yes	Urinary retention
C13	2	66/female	8	Lung cancer	Yes	Urinary incontinence + constipation
C14	2	82/male	27	Bowel cancer	Yes	Urinary incontinence

Site 1: Hospital tertiary palliative care unit.

Site 2: Hospice palliative care unit.

*Table 2*  
**Themes With Underlying Categories and Codes**

Themes	Categories	Codes
Losing control	Losing control over bladder and bowel	No control Change in control Regular movement Getting more control
	Discomfort, bother, and pain	Difficulty with mobility Catheter as uncomfortable Treatment worse I don't like the feeling Pain Continence in the bigger picture Odor Nighttime bothers me
	Challenges to dignity	Embarrassment Dignity difficult to maintain Now I am used to it
		Using pads Catheter as life-saver Managing fluid and diet Trying options Suppositories
Finding a way to manage	Management/interventions	Not knowing the options Took advice Not knowing what was tried I didn't get told
	Not knowing the options	Stick with what works Easiest way
	Easiest way	Health care professionals recommendations Family influence Kind Health care professionals actions Preferences followed Hospital is the worst Wait so much Helping with cleaning
Caregivers can help and can hinder	Effects of caregivers	

interventions in an attempt to reduce their embarrassment. Maintaining dignity was a challenge in the palliative care setting as all participants needed assistance with personal care:

When you stand there and you're butt naked and they are helping you wash there is not much more privacy you are losing with having someone help you (C4).

Despite the struggle with loss of dignity, many participants accepted their situation as they needed the staff to assist them with personal care. Being shy about receiving such necessary care was seen as pointless. The loss of dignity associated with being incontinent was downplayed as no longer an important issue. Staff treating patients with compassion and respect helped patients remain more dignified.

#### *Finding a Way to Manage*

In an attempt to reduce symptoms and improve quality of life at end of life, participants tried a variety of interventions in search of the best or easiest way to manage their incontinence but did not always understand what the physicians and nurses recommended.

As a management strategy, participants wearing absorbent pads described doing so to feel safe and

avoid, or at least contain, bladder and bowel accidents. Wearing pads was generally thought to be a good management strategy that some participants had tried before admission to the unit and was recommended by staff to patients. Participants also tried modifying fluid intake or inserting suppositories, with mild success in controlling elimination. Although catheters were perceived as uncomfortable, participants were satisfied with this intervention as the trade-off was avoiding the pain of ambulation:

...well it has been a lifesaver really because the pain with trying to get off the bed was getting to the point where it just wasn't worth it any longer (C2).

Participants did not know the options for bladder and bowel management and were rarely asked about their preferences. Some had no desire to learn about other management strategies, taking advice from physicians or nurses, either because they trusted them or felt they did not know anything themselves. Not knowing the options extended further back in the patients' journey, when life-saving treatment decisions were being made without fully understanding the implications for bladder and bowel function, leaving a feeling they had not been fully advised of what would

happen as disease progressed. This quote exemplifies the experience:

...with regard to the bowels, when I took the option of taking the radiation treatment no one told me that in many cases the adjacent bowel areas will be affected and the effect was not visible until a year after I got radiation (C11).

Participants would stay with a management option based on what was comfortable, convenient, and most importantly, the easiest to do. The options were recommended by the physicians and nurses. Participants did not use trial and error to find the best approach; once they found something that worked they stuck with it. They were even willing to put up with minor discomfort and minimizing a lack of esthetic appearance:

I got used to [the pull-ups] and they are not that bad. When I go out, they are a bit uncomfortable because I have to wear them under my clothes. I feel really bulky, but it's not that bad (C6).

### *Caregivers Can Help and Can Hinder*

Those providing care for the participants, health care providers and family, had both positive and negative effects on participants when it came to continence, not just psychologically, but socially and emotionally as well. Beyond assessment, diagnosis, and administration of medications and treatments, participants reported staff helped a lot with personal care. Participants expressed gratitude that nurses kept them clean, provided care to prevent development of wounds resulting from prolonged bed rest, and demonstrated compassion throughout this process. Responding to patients' needs quickly, along with pacing and taking pauses in personal care, eased discomfort:

...take 5 minutes extra we need and it won't be as rough and it will be easier to get to the next stage and go on (C10).

Sensitive communication with patients was important and including family members in conversations about care. Participants expressed concern about negative interactions that had occurred in prior experiences outside of palliative care, such as not responding to calls for assistance in a timely manner or even feeling degraded when incontinence occurred and a nurse brought in other nurses to laugh at the patient.

Some participants acknowledged personal care provided by family, as well as the morale boost family members provided when they came to visit. Appreciation of the personal care provided by others such as a spouse was identified, as was the burden carried by family member when compared with the care received on the unit:

...it's about the same kind of care but it's done by 3–4 people when [my wife's] done it by herself (C12).

In contrast, to protect their dignity, other participants indicated they did not want certain family members to take care of them, such as offspring of the opposite sex or those who saw continence care as an unappealing chore:

I would have no dignity whatsoever because they would not help me with that kind of stuff, like my older daughter said to my sister "you better go help mom because I sure as hell don't want to be down there looking at her ass." That to me is taking away my dignity, so I don't let her near me obviously (C7).

### *Discussion*

Participants experienced loss of control over bladder and bowel function, sometimes facing discomfort and pain as a part of management. They identified remaining clean while avoiding humiliation as an important part of maintaining some degree of control. Receiving continence care challenged their sense of dignity, but dignity was at times a small matter compared with the larger issues they faced. Participants did not recall being asked about their preferences for care and accepted management recommendations from physicians and nurses with little interest in exploring alternatives. Participants reported loss of dignity primarily with loss of privacy and humiliation; however, dignity is subjective, varies by person and throughout their illness.<sup>23</sup> Participants did not want to surrender their dignity but found it was challenging because they required assistance with toileting and cleaning themselves. Patients were willing to give up on some dignity to preserve more important things such as staying clean and avoiding pain. What participants prioritized as most important closely aligned with a study of nursing home residents at end of life who found pain, responsive behavior, and urinary incontinence to be the most impactful symptoms.<sup>24</sup> Prioritizing pain and symptom management follows a patient's wishes for improved quality of death.<sup>25</sup> This evidence suggested that loss of dignity was not important at end of life compared with previous research.<sup>6</sup> Dignity may not be as much an issue at end of life compared with healthy individuals.<sup>26</sup> This study suggests loss of dignity is accepted at end of life out of necessity as patients prioritized other issues and represents a "trade-off." The concept of trade-offs, the weighing of benefits and risks when making choices about care, has been described in studies of preference in which cancer patients living with pain chose between pain control and minimizing drug side effects<sup>27,28</sup> and other factors including out-of-pocket costs.<sup>27</sup> Further investigation is needed to understand this acceptance of loss of

dignity with continence care, whereas receiving exceptional care for other symptoms.

Containment products and catheters are typically used to manage incontinence and are considered as methods of last resort<sup>29</sup>; however, at end of life, they may be the best choice. Containment products were commonly used and participants were satisfied with them, but not one product suits all. Units should carry different product options to meet individual patient needs and preferences.<sup>30</sup> Catheters provided relief when mobility was a challenge for patients and getting out of bed was painful. These options will not cure incontinence, but they do align with the objective of managing symptoms at end of life.<sup>9</sup> Unfortunately, participants could not recall conversations with care providers and what treatments had been tried, which is not uncommon,<sup>31</sup> nor if they were asked about their care preferences. Furthermore, palliative patients often do not engage in decision-making.<sup>32</sup> It was not clear if participants would rather be knowledgeable and more involved in decision-making or were comfortable with letting caregivers make decisions because they trusted health care professionals. Participants would stick with health care professional recommendations or what was easiest as long as it alleviated some pain or discomfort. Even so, health care professionals should attempt to involve patients in decision-making by asking what their preferences are and what aims of care are most important to them and incorporate these into routine care.<sup>9</sup> It would be valuable to conduct an intervention study to examine if having a better understanding of and incorporating patient preferences concerning bladder and bowel care improves patients' quality of life as they near end of life, a question not pursued in this study.

Although assessment and appropriate interventions are crucial, interviews revealed that kindness and exceptional communication with health care providers was important to preserving dignity and maintaining quality of life. Taking an extra few minutes and caring for patients as people, not a task, improved patient experiences. This aligns with a recent study of 191 patients in late stages of palliative care who expressed the most important things to them were medical care, honesty, being treated with respect and empathy, and the atmosphere of their surroundings.<sup>33</sup> Having a discussion early on about goals of care can increase patients' quality of life and have positive family outcomes.<sup>34</sup> This requires effective communication, and physicians should be educated to have constructive conversations regarding continence. Results of this study showed that patients who were not treated respectfully suffered because of this. Another important aspect for patients was waiting to be helped to the washroom.<sup>35</sup> Waiting times for the sites in this study were low, and staffing ratios were higher when compared with long-term care settings. Staffing

numbers and other responsibilities affect when patients can receive care; however, continence care should be based on individual patient needs. Excessive waiting was associated with considerable misery.

### *Limitations*

Participants in this study were receiving palliative care from staff with specialized training. Their experiences may be different from other hospital patients. These perspectives reflected cognitively able patients as there are inherent issues in understanding preferences of patients lacking cognitive function.

### *Conclusion*

This exploratory study sought to understand patient preferences for continence care and aims for care at end of life. Acceptable ways to manage appeared to be the use of continence pads and catheters if they met guidelines for use, such as immobility or discomfort. As patients approached end of life, they were willing to give up some dignity if it was required to address symptoms, which caused them more distress, like pain. Health care professionals and family have an important role in caregiving and in their social interactions. Patient preferences for continence care should be ascertained and incorporated into care as much as possible at end of life.

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## Appendix

### Appendix A

#### Consolidated Criteria for Reporting Qualitative Studies (COREQ): 32-Item Checklist

No	Item	Guide Questions/Description	Criteria Met (Page)
Domain 1: Research team and reflexivity			
Personal characteristics			
1.	Interviewer/facilitator	Which author/s conducted the interview or focus group?	4
2.	Credentials	What were the researcher's credentials? e.g., PhD, MD	Title page
3.	Occupation	What was their occupation at the time of the study?	4
4.	Gender	Was the researcher male or female?	4
5.	Experience and training	What experience or training did the researcher have?	4
Relationship with participants			
6.	Relationship established	Was a relationship established prior to study commencement?	4
7.	Participant knowledge of the interviewer	What did the participants know about the researcher? e.g., personal goals, reasons for doing the research	4
8.	Interviewer characteristics	What characteristics were reported about the interviewer/facilitator? e.g., bias, assumptions, reasons, and interests in the research topic	3
Domain 2: Study design			
Theoretical framework			
9.	Methodological orientation and theory	What methodological orientation was stated to underpin the study? e.g., grounded theory, discourse analysis, ethnography, phenomenology, content analysis	3, 4
Participant selection			
10.	Sampling	How were participants selected? e.g., purposive, convenience, consecutive, snowball	3, 4
11.	Method of approach	How were participants approached? e.g., face-to-face, telephone, mail, e-mail	4
12.	Sample size	How many participants were in the study?	5
13.	Nonparticipation	How many people refused to participate or dropped out? Reasons?	Not recorded. Patients were free to refuse to be referred to the study.
Setting			
14.	Setting of data collection	Where was the data collected? e.g., home, clinic, workplace	3
15.	Presence of nonparticipants	Was anyone else present besides the participants and researchers?	4
16.	Description of sample	What are the important characteristics of the sample? e.g., demographic data, date	5, <a href="#">Table 1</a>
Data collection			
17.	Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	4
18.	Repeat interviews	Were repeat interviews carried out? If yes, how many?	4
19.	Audio/visual recording	Did the research use audio or visual recording to collect the data?	4
20.	Field notes	Were field notes made during and/or after the interview or focus group?	4, 5
21.	Duration	What was the duration of the interviews or focus group?	5
22.	Data saturation	Was data saturation discussed?	4
23.	Transcripts returned	Were transcripts returned to participants for comment and/or correction?	4, single interviews only due to participant health status
Domain 3: Analysis and findings			
Data analysis			
24.	Number of data coders	How many data coders coded the data?	4, 5

(Continued)

*Appendix A*  
**Continued**

No	Item	Guide Questions/Description	Criteria Met (Page)
25.	Description of the coding tree	Did authors provide a description of the coding tree?	<i>Table 2</i>
26.	Derivation of themes	Were themes identified in advance or derived from the data?	6
27.	Software	What software, if applicable, was used to manage the data?	6
28.	Participant checking	Did participants provide feedback on the findings?	4, single interviews only due to participant health status
Reporting			
29.	Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g., participant number	6–10
30.	Data and findings consistent	Was there consistency between the data presented and the findings?	6–10
31.	Clarity of major themes	Were major themes clearly presented in the findings?	6–10, <i>Table 2</i>
32.	Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	No minor themes; Diverse cases within themes (e.g., Theme 1 - most participants perceived catheters as painful; Theme 2: one participant found the catheter was a trade-off to the pain of moving).

## *Appendix B*

Demographic Information	
Participant Number	_____
Location/site	_____
Sex: Male	_____ Female _____ Age _____
Marital status:	_____
<input type="checkbox"/> Married	
<input type="checkbox"/> Single	
<input type="checkbox"/> Widowed	
<input type="checkbox"/> Separated/divorced	
Do you live:	_____
<input type="checkbox"/> Alone	
<input type="checkbox"/> with husband/wife	
<input type="checkbox"/> with other family/friends	
When were you admitted to the hospital/hospice? Date or days (LOS)	_____
Where you receiving home care prior to coming to the hospice? Yes No	_____
Underlying reason for being in the hospice?	_____

### *Semistructured Interview Guide*

1. Describe your experience with bladder and bowel issues.  
Probes: Pre-existing incontinence or other LUTS, change since admission to hospital/hospice (why?), the reason/part of the reason you were admitted to hospital/hospice, is your incontinence associated with your illness.
2. Can you describe how you addressed these concerns on your own?  
Probe: Where did you get the information?
3. Who has provided help with your incontinence? How have they done so?  
Probes: Palliative care nurse, home care, physician, family member
4. What kinds of strategies were tried? Which of these were used before admission (if previous incontinence)?  
Probes: New use of pads/more absorbent pads, catheters, laxatives/suppositories/enemas, timed toileting?
5. What do you think of the advice the physicians and nurses have given you about incontinence?  
Probes: Do you trust their opinions? Have you tried other options? Have you looked at other sources?
6. Have you had to wait for the physicians or nurses to help you? How has this impacted you?
7. How has your family helped you with your incontinence?  
Probes: Bought products, given you advice, helped you change, get to the washroom
8. Why is your incontinence something that concerns you?  
Probes: Privacy concerns, dignity, avoiding loss of control, feeling safe, odor, body image. Which is the most important?
9. What kinds of preferences have the health care professionals asked you about?  
Probes: Who? Where they followed?
10. How important is managing your incontinence to you? How does this impact your decisions with care?
11. What treatments do you think are acceptable to you to manage any bladder or bowel control problems?  
Probes: Why are these better for you compared with other treatments? Of these, which is the best?