

## Commodes: inconvenient conveniences

John R Naylor, Graham P Mulley

### Abstract

**Objectives**—To investigate use of commodes and attitudes of users and carers to them.

**Design**—Interview with semi-structured questionnaire of subjects supplied with commodes from Leeds community appliance centre.

**Subjects**—140 users of a commode and 105 of their carers.

**Results**—Main reasons for being supplied with a commode were impaired mobility (130 subjects), difficulty in climbing stairs (128), and urinary incontinence (127). Main concerns of users and carers were lack of privacy (120 subjects felt embarrassed about using their commode, and 96 would not use it if someone was present); unpleasant smells (especially for 20 subjects who were confined to one room); physical appearance of commode chair (101 users said it had an unfavourable appearance, and 44 had tried to disguise it); and lack of follow up after commode was supplied (only 15 users and carers knew who to contact if there were problems). Users generally either had very positive or very negative attitudes to their commodes but most carers viewed them very negatively, especially with regard to cleaning them.

**Conclusions**—Health professionals should be aware of people's need for privacy when advising them where to keep their commode. A standard commode is inappropriate for people confined to one room, and alternatives such as a chemical toilet should be considered. Regular follow up is needed to identify any problems such as uncomfortable or unsafe chairs. More thought should be given to the appearance of commodes in their design.

### Introduction

Commode chairs have been in use for centuries. Manufacturers from the last century produced commodes from materials such as mahogany, beech, cane, wicker, and leather (fig 1). Current commode chair designs are more utilitarian (fig 2). The different types of commodes currently in use have been described previously.<sup>1</sup> Although they are used by many disabled older people, there is very little published research on this subject. The only other community study of toilet aids revealed that 33% of people aged over 75 living in Melton Mowbray used aids such as commodes.<sup>2</sup> This study did not investigate the nature of the difficulties the commode users were facing. As it is likely the use of commodes by older people living at home will increase and as many of our patients were unhappy with their commodes, we carried out a community based study to investigate the use of commodes.

### Methods

All those who had been supplied with a commode from the Leeds community appliance centre were identified from the centre's database. Of 427 people

listed, 150 were randomly selected by means of a random number generator. These people were then contacted by telephone or letter and asked to take part in our study. Those who agreed were visited in their homes by one of us (JRN) and were interviewed with a semi-structured questionnaire. We measured the subjects' independence in activities of daily living with the Barthel index, an ordinal scale that has been adopted by the Royal College of Physicians and the British Geriatric Society as the recommended scale for assessment of such activities.<sup>3</sup> High scores are indicative of greater independence in performing self care activities. If possible, the subjects' informal carers were also interviewed.

As this study was primarily concerned with use of commodes rather than management of urinary continence we did not contact men who had been supplied with bottles as a means of managing their incontinence.

### Results

#### SUBJECTS

Altogether 140 subjects, 102 women with a median age of 75 (range 63-94) and 38 men aged 71 (55-90), and 105 carers were interviewed. The median Barthel score of everyday living activities for the subjects was 15 (range 4-20). Of the 64 subjects who lived alone, 35 had no single identifiable carer or were not receiving any formal or informal support, and their Barthel score was 18 (13-20). For 25 of the 76 subjects living with someone else details were obtained only from the carer. This was usually because these subjects were cognitively impaired. In 80 cases both the subject and the family carer were interviewed together. In 51 cases carers were resident, and 30 were spouses.

#### PROVISION OF COMMODES

The provision of a commode had usually been initiated by occupational therapists (73 from hospitals and 26 from the community). District nurses had assessed the need for the commode in 34 cases and general practitioners had in seven. The reasons for providing commodes are given in the table. Impaired mobility, difficulties with climbing stairs, and urinary incontinence were the commonest reasons. Concern over safety at night, especially fear about falling when going to the toilet, was another reason for supplying a commode. Of the carers interviewed, 31 felt that the principal reason for the commode's supply was to alleviate their burden of care. Only 15 of the sample of 220 people interviewed knew whom they would contact in the event of problems with the commode. In each case this was the general practitioner though the commode had usually been supplied by social services.

Most of the subjects (112) had been advised by health professionals about where to keep their commodes, and safety was the main factor in choosing a location. Many of the subjects, however, were



FIG 1—Commode chair typical of the period around 1910 made from beech with cut velvet upholstery

THACKRAY MEDICAL MUSEUM, LEEDS



FIG 2—Contemporary commode chair comprising a tubular metal frame and moulded plastic seat

Department of Medicine for the Elderly, St James's University Hospital Trust, Leeds LS9 7TF

John R Naylor, senior registrar

Graham P Mulley, professor

Correspondence to:

Dr J R Naylor, Care of the Elderly, St Luke's Hospital, Bradford BD5 0NA

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Reasons why 140 people were supplied with commodes. Values are numbers of subjects

Impaired mobility	130
Difficulty in climbing stairs	128
Urinary incontinence	127
Exhaustion of carer	51
Night time safety	40

unhappy about loss of privacy, and some kept their commodes in a more private place than that recommended by the health professional. Seventy seven subjects kept and used their commode in their main living room; of the 60 subjects who had a commode in their bedroom, 31 had been given two commodes and kept one beside their bed; of the 20 subjects confined to one room, nine placed their commode in the bedroom rather than their main living room; 44 put it in a different room; and 15 left it under the stairs or in the hall.

#### USE OF COMMODES

Most people used the commode only for urination and continued to use their toilet for defecation. Only 16 used it for both urine and faeces. Most subjects (120) felt embarrassed when using their commode, and 96 would not use it if there was another person in the room. Of the 44 people who kept their commode separate from their main living room, 29 gave privacy as the main reason for this, and 39 people who used their commode in the main living room covered themselves in a towel or sheet when they sat on the commode. Most (86) used the commode during the day only and used the toilet at night if necessary; 16 used the commode only at night; and 64 used it both day and night. Four subjects kept a chamber pot or bucket beside the bed.

Of the 120 people using the commode during the day, 76 had it emptied immediately after use, 24 had it emptied at intervals during the day (usually two or three times), and 20 people had it emptied once a day, usually in the evening. At night only six people emptied it straight after use. The commode was usually emptied and cleaned by someone other than the user, usually the resident carer. Of the 31 subjects who lived alone with no single identifiable carer, most (24) emptied the commode themselves. All 76 resident carers and 24 of the non-resident carers regularly cleaned the commodes.

#### ATTITUDES TO COMMODES

Forty nine subjects reported that using their commode was very unhygienic. All those who used their commode for defecation remarked on the problem of odours despite their using deodorants, and nine complained that even when the commode was used only for urine it had a persistent and unpleasant smell. Altogether, 65 subjects reported having no problems in using their commode, but 66 thought their commode was unsafe or uncomfortable, or both: 26 found the commode very uncomfortable to sit on for any length of time; 20 found it too low and had problems standing up from it; and 20 had fallen while getting on and off the commode in the past six months. Several of the carers reported difficulties in helping with transfers because of the height of the commode. In addition, 101 of the subjects said that their commode had an unfavourable appearance, and 44 had attempted to disguise it in some way. All the 100 carers who regularly cleaned the commode found the task unpleasant, but 47 felt it was part of the duty of care. Fifty five reported loathing this task and would have liked some alternative system such as a chemical toilet.

The overall rating of the commode differed between user and carer (fig 3). Ratings given by the users were either very positive (51 scored the commode at 8 or 9) or very negative (40 scored it at 2 or 3). Ratings by carers were much more negative: 77 scored the commode at 1-3, and only 15 gave it a rating of 6 or more. On 80 occasions commodes were scored by both user and carer: in 39 pairs one rated the commode at  $\leq 5$  and one at  $> 5$ , in 36 pairs both scored it at  $\leq 5$ , and in five pairs both scored it at  $> 5$ . Only 12 of the paired ratings agreed. In 25 of the 29 pairs that were within

one scale point of each other both individuals scored the commode at  $\leq 5$ .

#### Discussion

This survey was based on interviews with 220 people, 115 subjects who had been supplied with a commode and 105 carers. The subjects had many degrees of physical disability, as indicated by their Barthel scores. As might be expected, those living alone were less disabled than those living with a friend or family member, but there were no apparent differences between the two groups in the reasons why commodes were supplied. For individuals with very limited mobility the commode seemed to be an important factor in their remaining at home.

#### POOR COMMUNICATION

A noteworthy feature of this study was that although much effort had been spent at the initial assessment, little follow up had occurred. Often the commode had been supplied after discharge from hospital and was delivered without any instruction on maintenance or any information about whom to contact in the event of problems. "A couple of months after the commode arrived the plastic bowl split. I didn't know what to do or who to ask so I just went out and bought a washing up bowl." The lack of information, instruction, and follow up for people supplied with aids or appliances has previously been identified.<sup>4</sup> It is frustrating that little has changed in this regard. In a few cases two commodes had been provided and this was felt to be appropriate. This contrasts with a previous report of the provision of multiple items of equipment.<sup>5</sup>

Many of the people interviewed felt that they had been given no opportunity to voice their concerns about their commodes and did not know whom to contact for help and advice: "My doctor calls regularly but he never asks about the commode and I don't like to mention it to him," "It was as if once I had got the commode everybody thought my problem had gone away." Disabled people prefer to talk to individuals rather than organisations. Once a piece of enabling equipment has been delivered regular follow up is necessary, particularly when people live on their own. Better follow up should also improve safety: in our study a few people had placed wooden blocks under their commode as they found it to be too low, and all those who fell while transferring were in this group.

#### DIFFERENT OPINIONS OF USERS AND CARERS

When asked to rate the commode, users differed

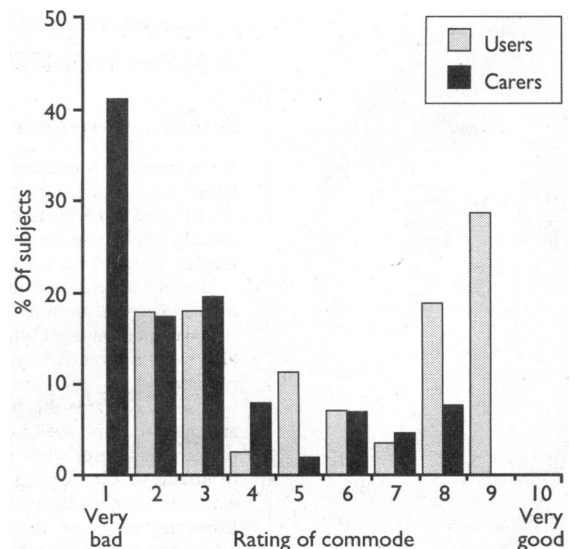


FIG 3—Rating of commodes from very bad to very good by 140 users of commodes and 105 of their carers

from their carers. Most users rated their commode either very positively or very negatively, which was surprising as older people generally report moderate opinions. Comments such as "I used to be wet all the time, now I can stay dry," "It's really handy to have beside the bed at night," "I have to live downstairs now and if I didn't have this I couldn't stay, I'd have to go into care," and "It's better than a bucket" illustrate some of the more positive attitudes towards the commode. Most carers, however, rated the commode as very bad. This was usually when the carer was the spouse and almost always when the commode was used for defecation. Where paired opinions were available carer and user agreed when both rated the commode negatively; when the user viewed the commode positively the carer's assessment was usually negative.

The divergence of opinion about the commode, when users had a more positive attitude to it than their carers, may reflect the greater degree of adjustment to disability and handicap made by the subjects compared with their carers. Many spouses experience problems in providing intimate physical care. Such difficult and ambivalent feelings may be transferred onto the commode: "Every time I see the thing it reminds me of the things he can no longer do," "It [the commode] sits there in the corner and reminds me of his stroke." Feelings of anger were common: "I sometimes just sit and swear at it," "I often give it a kick as I walk past." However, the commode was sometimes useful in helping carers cope with such feelings: "If I have had a good shout at the thing when I'm cleaning it I don't have to shout at my wife when she soils the bed," "When I feel like I want to hit him I take a stick and beat the living daylight out of it. I even once broke the seat." Frustration and sadness often accompanied the anger: "This wasn't what I'd imagined our retirement would be like. When I clean it out it feels like I'm flushing my life down the toilet," "I wake up in the night and think she's going to be well again. Then I see the commode by her bed and just cry." When the carer was a non-resident friend or family member, however, the general rating tended to be slightly higher. This may reflect the choice made by such carers to provide intimate physical care, they may have a more positive view of the commode as part of that care.

#### LACK OF PRIVACY AND HYGIENE

Loss of privacy was a major reason for commode users' unhappiness, and some placed privacy above safety when considering where to place the commode. "The occupational therapist suggested I keep it in the

hall because there was enough space to turn round. Once I got home I was embarrassed because anyone could have come through the door. I keep it under the stairs now. It's quite a struggle and I often bang my head getting off, but I like to have the door shut when I'm on." When the site for the commode is chosen the users ought to have a say. More thought needs to be given to how people with disability may be given some privacy—perhaps foldaway screens could be considered.

For those people living in one room and using their commode for defecation, odour was a serious problem to which none of the people interviewed had found a satisfactory solution. We believe that a standard commode chair is inappropriate in such situations and alternatives should be found. Some form of chemical toilet might be an improvement, while air purifiers and ionisers might help to limit faecal odour.

#### POOR DESIGN

Many people in this survey found the appearance of their commode chair unsatisfactory. "Day after day I have to sit there and look at it. It looks ugly. Why can't they be prettier?" "When anybody comes round I might as well hang a sign on it. Everybody knows what it is." Commode chairs were once valuable and aesthetically pleasing articles of household furniture (fig 1). Further research is needed to determine those designs most acceptable to people using commodes. Although production costs must be considered in manufacturing aids and appliances, such factors should not override the needs of the user. The design of commodes should not be determined purely by function with no thought given to their appearance.

We thank the Leeds community aids and appliance centre for help in carrying out this study; the William Merritt Disabled Living Centre, Leeds, for advice; the Thackray Medical Museum, Leeds, for providing details of antique commode chairs; and many district nurses and occupational therapists for their helpful comments.

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## A MESSAGE I WOULD LIKE TO LEAVE BEHIND

### A short, sharp lesson in communication

It presented as a painless swelling in front of and slightly below the left ear; and after antibiotics had been taken for a suspected ear infection it had progressed to become a slightly larger painless swelling in front of and just below the ear. Referral for surgical opinion was decided on, and at the subsequent consultation a confident diagnosis of a mixed parotid tumour was made. Arrangements for surgical excision went ahead and the appointed day came and went uneventfully with the offending swelling duly removed.

Some days later the patient who had previously been attached to this swelling attended the hospital for the removal of sutures while his pregnant wife stayed at home to attend to the existing toddler and the ironing. These activities were suddenly interrupted by a telephone call from the sister of the surgical ward at the hospital expressing disappointment at the wife's non-attendance at

the hospital with her husband as it had been discovered that he was suffering from Hodgkin's disease. An outpatient appointment for him to be seen by a consultant from Christie's Hospital in Manchester would be sent. The patient had not been told of the diagnosis. That was all.

How do I know? I took that telephone call and it was for me, at home with toddler and unborn child. Fortunately, radiation treatment was effective and my husband is alive and well 30 years later. Memories of much of the trauma and anxiety of the subsequent years have faded but that devastating and insensitive telephone call so many years ago has never been forgotten. It taught me a lot.—FIONA HASLAM is a retired medical practitioner in Bolton

We are delighted to receive submissions of up to 600 words on *A paper (or patient) that changed my practice, A memorable patient, The one message I would like to leave behind,* or related topics.