Dealing with patients with concurrent dementia and urinary incontinence

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The management of incontinence is often a neglected area of community care, even more so when allied to older people, and it is essential that community nurses consider the effect of the ageing process and its impact on continence. Often, this can involve the specific effects of dementia and the management of urinary incontinence can then become complex due to the range of practical approaches required and the need to adjust these for each patient. A large percentage of the community nurse’s time is spent supporting carers; therefore, it is essential to consider their feelings when suggesting any strategies as they may feel that they are already incorporating them in the patient’s daily activities. It is also important to focus on few key elements of advice around incontinence and to listen empathetically to appreciate the challenges experienced by carers, which will help in identifying suitable strategies.

The broad aim of this article is to encourage those involved in patient care to be more proactive in their continence promotion.

WHAT IS DEMENTIA?

Dementia has been described as a syndrome occurring as a result of a disease of the brain, which is chronic or progressive in nature (World Health Organisation [WHO], 1992). While this may be a very simple definition, it is true that in recent years awareness of dementia has grown as the condition has attracted more media headlines (McGinley, 2015).

According to the Alzheimer’s Society (2014), the recent increased attention is critical to wider understanding of a disease that in the UK alone affects an estimated 840,000 people, accounting for 7.1% of the population over the age of 65.

Dementia often presents as a range of symptoms that arise due to an impairment of several higher cortical functions, which include memory, thinking, comprehension, learning and judgement (Getliffe and Dolman, 2007; McGinley, 2015). McGinley (2015) highlighted that there are various types of dementia and it is important that community nurses know which type patients have, as the presentation can be different in each case and treatment needs to be individualised.

According to NHS Choices (2016), there are four main types of dementia (see Table 1):

- Alzheimer’s disease
- Vascular dementia
- Dementia with Lewy bodies
- Frontotemporal dementia

Early symptoms of dementia (sometimes called cognitive...
Impairment (are often mild and may get worse only very gradually. This means family and spouses might not notice initially. For this reason, the family of patients should be advised to talk to the GP sooner rather than later if they are worried about a relative’s memory problems.

The speed at which symptoms develop depends on the cause of the dementia as well as the patient’s overall health. This means that the symptoms and experience of dementia can vary greatly from person to person. Some people may also have more than one condition, for example, they may have Alzheimer’s disease and vascular dementia simultaneously.

While dementia can have many symptoms that are similar irrespective of the cause, the different forms of dementia do have some unique symptoms (Table 1). Similarly, the diagnosis of dementia varies according to behavioural, emotional and physical changes, each of which can have an impact on the patient’s dietary and fluid intake.

Maintaining health and nutrition in someone with dementia is important and if the person does not eat/drink enough or eats/drinks unhealthily, they can become susceptible to other illnesses, which can in turn lead to them becoming even more confused.

Common food-related problems for people with dementia include:

- Not recognising foods or drinks they like
- Forgetting what food or drink they order
- Refusing or spitting out food or drink
- Resisting being fed or helped with drinks
- Asking for strange food or drink combinations.

This behaviour is usually due to confusion, or irritation caused by dental problems, rather than awkwardness.

CONTINENCE AND DEMENTIA IN THE COMMUNITY

Continence promotion in dementia is complex because of the disease’s presentation and the affect it has on activities of daily living. A person with dementia may simply forget to go to the toilet, or may forget where the toilet is. They may also have lost the ability to tell when they need the toilet.

Getliffe and Dolman (2007) outlined how the management of incontinence in people with dementia can be complex as it involves multiple cognitive problems, which can have a profound effect on daily life. They also described the impact cognitive impairment can have on a person’s personality and ability to plan toilet visits. Going to the toilet requires a variety of cognitive skills and this process can break down at any point, with, for instance, the person having difficulty finding or even recognising the toilet, resulting in inappropriate ‘wetting’ (Stokes, 1987).

There are a range of practical measures required that the community nurse can implement or advise carers to implement:

- Put a photo of a toilet on the toilet door
- Keep the toilet door open and make sure that the person with dementia can easily access it
- Make sure they can remove their clothes; some people with dementia struggle with buttons and zips
- Look out for signs that they may need to go to the toilet, such as fidgeting or getting up and down from a seat.

Often, a large proportion of the community nurse’s time is spent supporting carers, a demanding role as carers often experience physical and emotional problems (Stokes, 1987). It is particularly important that those working with these patients are supported with strong leadership (McInley, 2015), which facilitates a flexible approach to regular toileting times. It is also vital that easy-to-follow toilet signs are in place in clinics and nursing homes for example, to assist in triggering the person’s memory (Wilson, 2003).

Functional assessment

Wilson (2003) stated that poor mental function may be associated with incontinence and that functional assessment could verify whether a person was able to interpret physical signals telling them to go to the toilet.

According to Wilson (2003), a functional assessment could also help to assess if a person was able to understand and obey instructions, and whether they had the desire to overcome their continence problems.

A functional assessment can identify problems, devise appropriate solutions, and implement and review progress (Getliffe and Dolman, 2002; Wilson, 2003). Part of the assessment
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Max was a 78-year-old man with dementia who was also experiencing urinary incontinence. He had been referred by his GP to the author’s continence advisory service for assessment and potential provision of containment products. He attended his initial assessment with his wife and presented with stress urinary incontinence and overactive bladder (this results from dysfunction of the nerves or detrusor muscle in the bladder), as well as symptoms of urgency, frequency, nocturia (urge to urinate frequently at night), and functional incontinence.

Max had a history of radical prostatectomy, vascular dementia, type 2 diabetes and arthritis. He also had poor eyesight. After his prostatectomy, the symptoms of Max’s overactive bladder were unlikely to improve and with damage to his bladder neck, he now had symptoms of stress urinary incontinence.

His wife Ruby was concerned that his memory had worsened as she described him as ‘muddled’, in denial about his dementia and reluctant to follow any of her instructions. She said that she was finding it harder to cope with his dementia and would be interested in arranging respite care. She also told the author that her husband was known to the memory clinic, which provided assessment, diagnosis and appropriate treatment for people experiencing early dementia.

Poor eyesight can make finding the toilet a problem, especially when the person is not in a familiar environment. Max was assessed for any eye problems and dexterity, particularly his ability to clean himself after going to the toilet, and manage containment products such as handheld urinals and pads.

Poor dexterity also hinders the ability to remove clothing, while unsuitable clothing or footwear can increase any mobility issues. Although Max lived in a one-storey flat and it was not difficult for him to access the toilet, his mobility was compromised and moving was difficult and painful for him due to his arthritis. Max’s dementia had also had an impact on his cognitive ability.

In the author’s clinical experience, the effect of dementia on continence varies. In the early stages, carers often report difficulties dealing with routine daily activities such as cooking or driving, for example Max often forgot to drink or wanted sweet drinks, which Ruby had to refuse as they exacerbated his diabetic symptoms.

Management
Due to Max’s cognitive impairment, management of his urinary incontinence was carer-led and included strategies such as toileting regimens to improve the condition (Ouslander and Schnelle, 1993). Some of the behavioural interventions suitable for people who are motivated or able to follow instructions, for example pelvic floor muscle exercises, were inappropriate for Max due to his cognitive impairment.

Ruby was instructed in how to perform bladder retraining techniques, which included reminding Max to go to the toilet every 3–4 hours. This technique can reduce voiding frequency and nocturia as well as increasing the volume voided (Milne, 2004). Max was also referred to the nutrition and dietetics department for nutritional advice as he was losing weight.

Ruby was advised to play his favourite music to encourage him to sit down and listen, or even to dance with him to calm him down and reduce his irritability and agitation, both of which can exacerbate urinary incontinence symptoms.

Some medications or changes in medication can aggravate the symptoms of incontinence and Max was undergoing a medication review to find out which would best manage his dementia symptoms. Some of the medications he was taking caused constipation and Ruby was advised to increase his fibre intake and if necessary request a laxative prescription from his GP. Max had some history of constipation and so Ruby was shown how to encourage him to be more active, eat little and often rather than having a big meal, and eat foods rich in fibre and fluids to treat his constipation.

Ruby was also advised to purchase loose and easily accessible clothing to help Max when going to the toilet. For some men, sheaths or body-worn collection devices are more acceptable than pads, however, Max could not use these even if his wife was taught how to apply them as he was likely to rip them off which could cause trauma. He was not suitable for intermittent self-catheterisation as he did not experience urinary retention; nor was he suitable for an indwelling catheter as he might remove this due to his lack of understanding.

Instead, Max was issued with all-in-one diaper-type pads. However, these can be hot and uncomfortable and can contribute to the development of incontinence dermatitis (Wilson 2003). Ruby was warned about this.

At the author’s most recent visit, Ruby reported that Max’s urinary incontinence was improving gradually as a result of following the treatment plan. Ruby reported that she was also able to better cope with Max’s urinary incontinence.
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process involves deciding how to solve problems such as the patient being able to reach the toilet or bathroom, dealing with clothing such as zips and buttons, and their transferring ability, e.g. from the bed to commode, wheelchair to toilet, etc. Functional problems can have a further impact on continence, for example urge incontinence requires the person being able to reach the toilet quickly (Williams and Gaylord, 1990).

Social function
It is important to establish whether a patient with dementia and continence issues lives alone or if someone is available to help them (Wilson, 2003). Other considerations include whether the person’s incontinence is restricting their social activity (Wilson, 2003).

According to Victor (2005), the type of household that older people live in is influenced by several factors including their age, gender, whether they are married and by their health status. Victor (2005) adds that a sense of wellbeing includes the capacity to make and sustain relationships, which are indicators of good mental health at any age, including the later years.

A good state of mental health in later life depends on older people achieving a reasonable standard of living and opportunities to contribute to family life and society. Living together has important implications in terms of health and wellbeing because of the care and support that people living in a couple can offer one another and because couples tend to cope better financially (Office for National Statistics, 2006).

Environmental considerations
The environment can have a considerable influence on continence and any assessment must establish if a patient’s problems are due to environmental factors such as:
- Furniture: for instance, chairs may be hard to get up from
- Toilet access: including how far away the toilet is
- Whether there are stairs or a stair-lift
- Height of the toilet seat
- Wheelchair access
- Heavy and/or awkward doors
- Availability of bedside commodes
- Adequate lighting: for instance are switches easy to turn on or off
- Presence of support rails or grab bars.

TREATMENT AND MANAGEMENT

Any treatment should be patient-focused and aim to improve urinary incontinence. Initially, it is often sensible to use management approaches such as providing containment products with a person with dementia, before implementing treatment such as pelvic floor muscle training or bladder training at a later stage if appropriate. Any interventions in older people or those with
dementia are the same as for younger patients, but significant improvements are likely to take longer with more support needed to motivate and ensure concordance (Wilson, 2003).

**Increased fluid intake**

Effective treatment and management of incontinence is dependent on a comprehensive assessment, which is essential if the cause of bladder and bowel problems are to be addressed effectively (Getliffe and Dolman, 2007). Reviewing a patient’s fluid input and output is an important element of continence assessment and is a core nursing activity (Morrison, 2000).

The aim of assessing fluid intake is to gain information on the volume, frequency and type of fluid (Bonner, 2004). This can be recorded using a fluid balance chart and allows the community nurse to quantify the patient’s symptoms, identify the type of urinary incontinence present, develop a treatment programme and monitor progress (Bonner, 2004).

Adequate fluid intake helps to keep the urinary tract and kidneys healthy, but a reduced fluid intake increases the risk of urinary tract infections (British Nutrition Foundation [BNF], 2014). Inadequate hydration is one of the main causes of acute kidney damage and is also one of the most common causes of constipation (BNF, 2014). In individuals who are not adequately hydrated, drinking more fluid can increase stool frequency and enhance the beneficial effect of fibre intake (BNF, 2014).

Adequate fluid intake is also vital for good general health (Dallosso et al, 2003), particularly in maintaining bowel and bladder health. Bladder health is especially linked to an adequate daily urine output, which, in turn, is influenced by fluid intake (Addison, 1999). Conversely, excessive intake may increase continence problems as, although uncommon, it is possible that drinking a lot of water can lead to too-frequent urination (Bonner, 2004).

The DH (2000) requires that patients with bladder and/or bowel dysfunction are given general advice about healthy living, which should include information on drinking appropriate fluids in sufficient quantities. The provision of fluid intake advice is a crucial part of the community nurse’s role and will contribute greatly to reducing continence problems, bladder infections and constipation, as well as promoting general wellbeing (Bonner, 2004).

Some older people and those with dementia may be reluctant to drink so as to avoid the need to go to the toilet (BNF, 2014), however, fluid restriction does not improve bladder issues but rather exacerbates symptoms of urgency, frequency and incontinence, as concentrated urine can irritate the bladder. Over time, low bladder urine volumes can result in a person’s bladder needing to be emptied when it is only partially full (Addison, 1999).

**Dehydration**

According to the BNF’s (2014) report, dehydration is more common in those with cognitive impairment and changes in functional ability. Swallowing difficulties, dementia and poorly controlled diabetes are more common in the elderly and are all associated with poor hydration.

The likelihood of dehydration may also be increased by medications including diuretics and laxatives and poor fluid intake can be related to the inability to feed independently and having poor access to fluids.

Older people are also vulnerable to dehydration due to general physiological changes in the ageing process but this can be complicated by conditions that involve a reduced sensation of thirst such as stroke or Alzheimer’s disease.

Reduced renal function is also a risk factor in people with poor fluid intake. The kidneys play a vital role in fluid regulation but their function deteriorates with age and the hormonal response to dehydration, which is vital to fluid balance, may be impaired.

**Behavioural interventions**

There are a variety of ways to help older people and those with dementia to reduce their risk of dehydration by recognising when they are not drinking enough and helping them to drink more. Strategies include identifying barriers to drinking, such as:

- People cutting down on fluids due to worries about not reaching the toilet in time
- Physical inability to make or reach drinks
- Older people sometimes experience a reduction in social drinking, such as sharing cups of tea.

A recent systematic review by Bunn et al (2013) found that preventing dehydration in older people is multifactorial and recommended increasing assistance, choice, availability of drinks and type of receptacles. Other strategies include ‘happy hours’, where carers can offer fluids and wet foods such as pureed fruit, yogurt, jelly, custard and soup.

It is also important to recognise that Care Quality Commission (CQC) standards apply to hydration as well as nutrition, with a focus on identification, assessment, and monitoring fluid intake (CQC, 2014).

Tiredness is also a factor as it can cause people to give up eating or drinking halfway through a meal, as well as leading to problems with concentration and/or coordination when eating or drinking (McGinley, 2003).
have been shown to reduce walking behaviours such as ‘wandering’. However, this term may not be clear why the person is walking and this is often referred to as ‘wandering’. However, this term is unhelpful because it suggests aimlessness, whereas the walking often does have a purpose to the person themselves.

Rather than dismissing it, it is important to think about how the person’s independence, safety and dignity can be preserved. Managing this behaviour can be difficult and treatment interventions such as music therapy and scheduled exercise have been shown to reduce walking in people with dementia (Robinson et al, 2006).

**Functional strategies**

When dexterity is a problem for patients, it is important that the patient’s clothing can be adjusted and accessed easily, by using trousers with elasticated waists and/or Velcro ‘zips’ for example.

**Containment products**

Containment products such as pads may be necessary either during ongoing treatment such as pelvic floor muscle training or when continence cannot be achieved. Companies are continually developing better products to suit individual patient’s needs. However, containment products should only be used when indicated by a comprehensive assessment, otherwise their use can lead to an increase in incontinent episodes.

Unnecessarily providing people with pads risks ‘encouraging’ them to pass urine into the pad rather than going to the toilet, thereby promoting incontinence rather than continence (Wilson, 2003). Of the types of pads available, the all-in-one diaper-type are not always more absorbent than body-worn pads, but they are perceived as more effective as they are all-enclosing.

Absorbent products may not always be the most effective option and there is a place for reusable products, which may be more pleasant and acceptable to some people. Reusable products include washable incontinence underwear, which is styled to look like normal underwear but offers discreet absorbency. The absorbent liner incorporated into these products prevents leakages and ensures long-term dryness, which means the person can go about their daily tasks with confidence.

However, one downside to reusable products at the author’s trust is that patients are only issued with a maximum of eight pairs of reusable underwear per year and are not issued with any disposable pads until the year ends. This can obviously be a problem if they experience a ‘bad day’ and have used all of their reusable underwear. In addition, drying reusable underwear can be difficult as they cannot be tumble-dried.

In the author’s experience, for men, sheaths or body-worn urine collection devices may be more acceptable than pads due to male anatomical structure and the fact that they stay in place, do not leak, and are comfortable and easy to remove. The author has noted, however, that some men feel absorbent products are more suitable for women and are reluctant to wear them for this reason.

Several occlusive devices, which are inserted into the vagina or urethra and prevent leakage by applying pressure or occluding the urethra, are also available. Most of these are more suited for women due to the female anatomy.

There are also various ranges of incontinence products designed to protect bedding, mattresses and chairs. These disposable and reusable bed ‘pads’ are useful for people with nocturnal incontinence but can be a risk to skin integrity through friction, as they can become ‘wrinkled’ and ‘lumpy’, and should therefore be used selectively.

**Pharmacological interventions**

Anticholinergics are a type of drug that blocks the action of the neurotransmitter acetylcholine in the brain and are used to treat conditions such as asthma, gastrointestinal cramps and muscular spasms, as well as being used to successfully treat incontinence. However, doses must be administered carefully in older people because the absorption, metabolism and elimination of drugs can be affected by the ageing process (Wilson, 2003). Most importantly, the body’s ability to eliminate drugs can be affected by reduced renal function, with the potential for an increased concentration of the drug in the body’s tissues and eventual toxicity (McGavock, 2011).

Some medications or changes in medication can also aggravate symptoms such as constipation, which can lead to people feeling bloated or nauseous and less likely to want to eat or drink (McGinley, 2015). To combat constipation, community nurses can encourage patients to be more active, to eat little and often rather than taking large meals, and to eat foods that are rich in fibre and fluids.

**Invasive treatment**

Invasive treatment such as surgery (see below), indwelling catheters, suprapubic catheters and intermittent self-catheterisation (ISC) should only be used as a last resort when conservative treatment measures have failed as they often cause complications (Wilson, 2003).

Indwelling and suprapubic catheterisation in particular can cause infection, blocking, bypassing (where a catheter blockage results in a build-up of urine which then leaks) and discomfort. Suprapubic catheterisation eliminates trauma and can be more acceptable to those who are sexually active (Addison and Mould, 2000; Simpson 2001), but this is often not appropriate for those with cognitive impairment as there may be a tendency to pull at the catheter.
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ISC refers to the procedure of passing a catheter into the bladder to drain urine through the urethra or other catheterisable means such as a Mitrofanoff continent urinary diversion (Getliffe and Dolman, 2007). ISC is the most appropriate option for those with incomplete bladder emptying.

**Surgery**
Various surgical options are available for urinary incontinence. For example, augmentation cystoplasty treats urge incontinence by using a piece of tissue taken from the intestine to enlarge bladder capacity. Surgery may be considered when conservative treatment measures have not been successful or where the person requires immediate definitive treatment (Wilson, 2003).

However, surgery may make detrusor instability symptoms worse and is often unsuccessful in those with an overactive bladder because of the damage to the muscle fibres which cannot be reversed (Wilson, 2003).

**CONCLUSION**
Incontinence has far-reaching consequences for patients with dementia and their carers, and the promotion and management of continence is often a neglected area of general healthcare practice. Clinical effectiveness in this area is dependent upon thorough holistic assessments that identify the types and causes of incontinence. This should be followed by tailor-made interventions that effectively manage the person’s continence issues, with the possible provision of containment products where necessary.

It is essential that community nurses consider the naturally occurring ageing process and its impact on continence, along with the more specific effects of dementia, particularly as the majority of dementia diagnoses are made in the over-65s.

The management of urinary incontinence in dementia is complex due to the range of practical approaches available and the need to adjust these for each patient. Often, a large percentage of the community nurse’s time will be spent supporting carers and it is essential to consider their feelings when suggesting any strategies, as they may feel that they are already incorporating these into the patient’s daily activities.

**REFERENCES**


