People with dementia may experience incontinence. It is important that both patients and their environment are assessed for possible causes

Maintaining continence in people with dementia

In this article...

- Why people with dementia have continence problems
- Assessing continence problems
- Environmental changes to promote continence and dignity

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Incontinence is not an inevitable consequence of having dementia, but continence can be an issue. Nurses need to have strategies in place to provide supportive continence care for people with dementia not only in hospitals, care homes and day care services, but also for those living at home alone or with a carer. For this to happen, the patient and home environment need to be assessed.

This article explores steps that can be taken to preserve the dignity of people with dementia if they become incontinent. The role of health professionals in hospitals is discussed, as well as changes that can be made in patients’ own homes.

The word dementia is used to describe the symptoms of conditions, including Alzheimer’s disease, where the person becomes increasingly and irreversibly cognitively impaired. Over time, people with dementia lose the capacity to undertake their own care and personal hygiene.

Perhaps the most disabling symptoms of dementia are related to a reduced capacity to work things out, or to learn new things. Since the majority of people with dementia are older many are affected by common sensory or physical impairments of ageing, such as reduced mobility or poor eyesight. Having dementia reduces their capacity to adapt to such impairments. In addition, depending on which brain pathology is causing the dementia, the disease may cause difficulty with depth perception or distractibility, making them more likely to fall or to fail to complete tasks.

Incontinence

Incontinence means involuntary urination or defecation. The symptoms of dementia may cause patients to urinate or defecate in an inappropriate place; although this act may appear to be entirely voluntary, it is still referred to as incontinence.

Maintaining dignity is paramount in continence management but can be particularly challenging when working with people with dementia. The World Alzheimer Report (Alzheimer’s Disease International, 2012) says incontinence “can be embarrassing to family members, who isolate themselves and the relative with dementia to avoid having to expose themselves to the reactions they anticipate from those outside the family”.

Managing incontinence

Everyone with a continence problem should be seen by a nursing or medical practitioner who specialises in urology or continence. However, this is less likely to happen if the problem starts in a person with dementia who is near the end of life. A diagnosis of dementia should not automatically exclude people from access to investigation and treatment.

Reversing or managing incontinence can save the family or care provider money, as well as making their lives easier. The decision on whether to organise a specialist referral can be based on assessment of the person with dementia. This should involve the GP, who will need a history, including the pattern of urination and the number of episodes of incontinence.

5 key points

1 People with dementia may not remember where toilets are situated
2 Patients should be assessed for possible causes of incontinence such as urinary tract infections
3 Environmental barriers can reduce patients’ ability to use the toilet, such as poor signs
4 Patients’ normal toilet habits and the vocabulary they use to describe them should be ascertained
5 Toilet regimens should be tailored to the needs of the individual

Signs should be just below eye level and unambiguous, with pictures and words
and defecation, and urination. The GP can examine the patient for problems that can be treated immediately, including:

- Urinary tract infections;
- Constipation;
- Enlarged prostate;
- Vaginitis;
- Prolapse.

Problems with pre-existing conditions such as Parkinson’s disease, stroke and diabetes should be considered and the patient’s drug therapy reviewed.

After this, dementia-specific issues should be assessed.

**Using the toilet**

If a patient is able to use the toilet, health professionals can support this. They should begin by working with the patient’s pattern, and use a range of techniques to find out what he or she can do independently and what difficulties they have. People with dementia might not:

- Recognise the need to go to the toilet at all or remember to go in good time;
- Be able to find the toilet or understand the furniture/fittings;
- Be able to get out of their clothes in time, or remember why they are on the toilet once they are there, or stay long enough to complete their task.

In these circumstances, staff should:

- Watch the patient’s usual patterns and offer encouragement to use the toilet discreetly, according to their natural rhythm rather than at a fixed time;
- Use the same vocabulary to describe going to the toilet as the patient does;
- Make sure there is always a toilet nearby and provide manageable clothes. It can be difficult for patients to manage pants, tights and zipped or buttoned trousers when they are in a hurry. Elasticated pants and trousers can help;
- Avoid giving the patient caffeine or fizzy drinks that might increase urgency;
- Consider well-fitting shoes, contrasting wall rails and aids that make it easier to get to the toilet safely and on time.

**Design**

Box 1 outlines simple adaptations that can be made in the home. As little change as possible should be made in a patient’s home, apart from increasing the light level, leaving the toilet door open or putting a sign on the door.

In a new environment such as a ward, patients with dementia will have difficulty finding out what he or she can do independently and what difficulties they have. People with dementia might not:

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**Managing behaviour**

Defecating and urinating in inappropriate places may have a number of causes.

Men with dementia sometimes urinate in corners and waste paper baskets. They may have been “caught short”, and be doing it as they might once have used a doorway on the way home from the pub instead of wetting themselves. Alternatively, they may once have lived or worked where the sanitary arrangements required them to urinate in a bucket, and may believe that what they are doing is appropriate. This can be tested by removing the basket and putting something distracting in the offending corner, such as a chair. Most importantly, staff must deal with such problems to avoid smell and distress to others.

It is vital to check if the patient has a treatable condition or is taking medication that would give rise to urgency. Otherwise, the strategies outlined above should be employed. Finally, if there is anything about the room – its colour, decoration, smell or layout – that reminds you of a toilet, this should be addressed.

**End-of-life care**

Towards the end of life, people with dementia may become more dependent and frail. Practitioners may need to consider how to manage incontinence in those who are immobile. The use of continence aids, such as body-worn pads, is preferable to indwelling urinary catheters, which can cause infection. Patients with dementia may be experiencing pain but unable to communicate this. Following assessment, prescribed pain relief should be given routinely when providing personal care such as washing and changing pads or bed linen.

Faecal incontinence may occur at the end of life, and a faecal management system may help to prevent skin damage and infection, and to maintain dignity by limiting odours (Yates, 2011).

**Conclusion**

It is important to take pride in the delicacy and skill with which your team manages incontinence. At the very least, we must maintain the dignity of our patients and their families by approaching incontinence in dementia in a positive and practised way. **NT**

**References**
