

Dementia and Continence Care

Dementia Training Study Centre
March 2009

Presented by: Dee Sutcliffe



Continence Advisory Service of WA

Continence Advisory Service of WA

Objectives:

At the end of the session
participants should be able to:

- Describe what is meant by continence care
- Describe the effects of dementia on bladder and bowel function, including incontinence
- List ways in which continence care can be improved for the person with dementia

Continence care

Continence care has been defined as “all measures directed toward the prevention, improvement and or management of urinary incontinence”

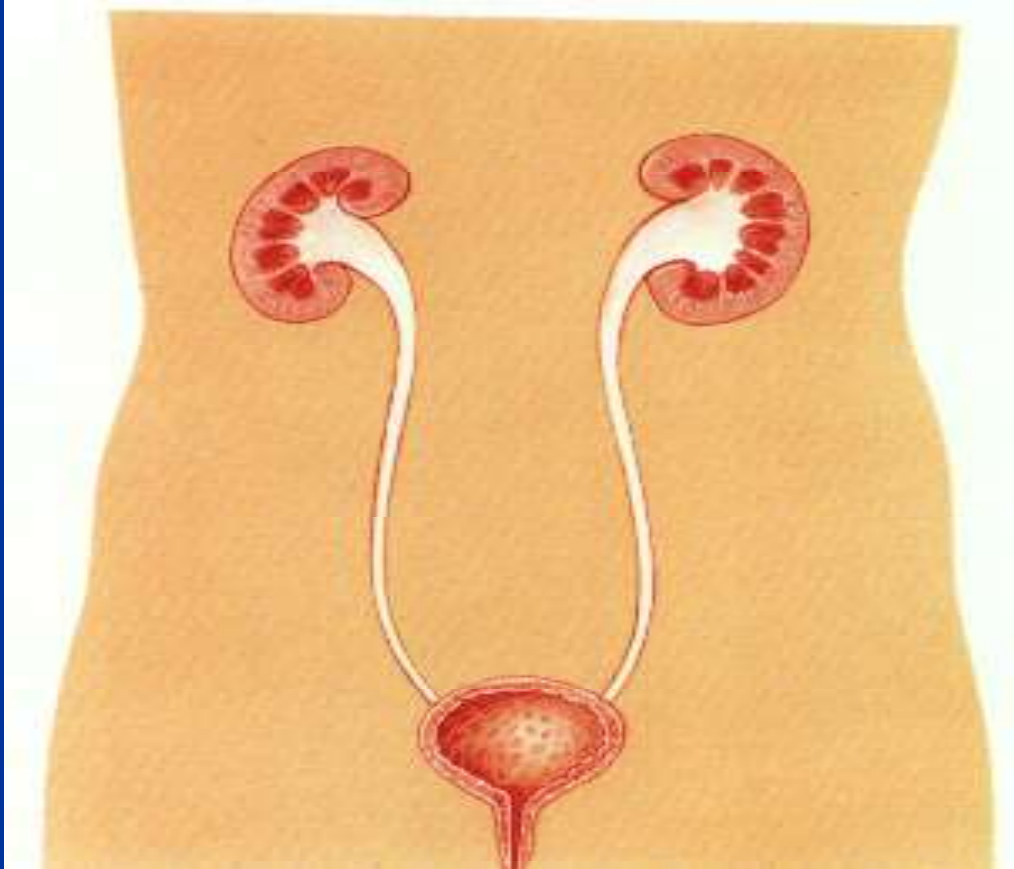
In this presentation faecal incontinence will be included within the concept of continence care.

Over 4 million Australians of all ages have problems with bladder and bowel control.

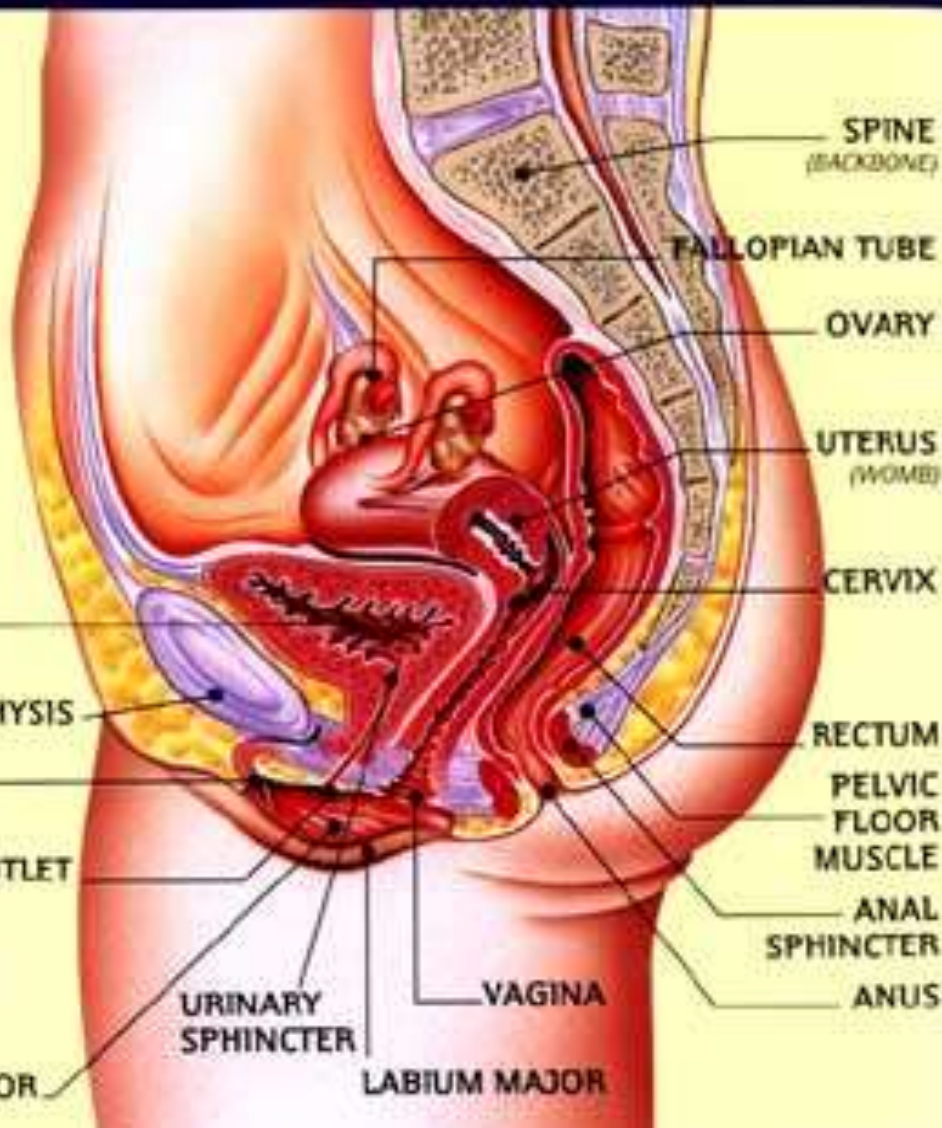
Incontinence is one of the top three reasons that result in people being admitted to residential care. 50 – 80% of nursing home residents are incontinent.

It is the second highest reason in the USA and UK.

A brief overview of bladder function



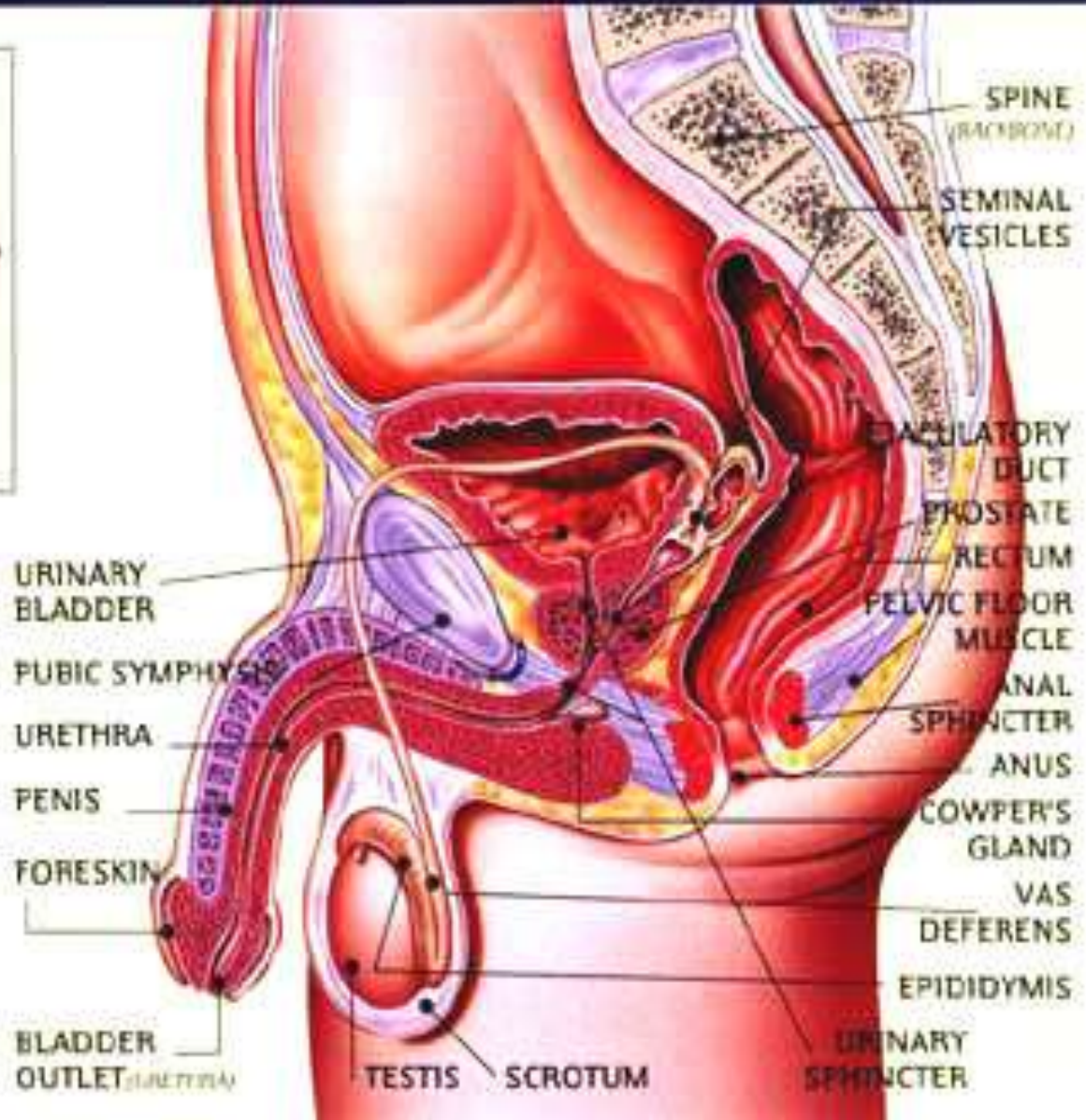
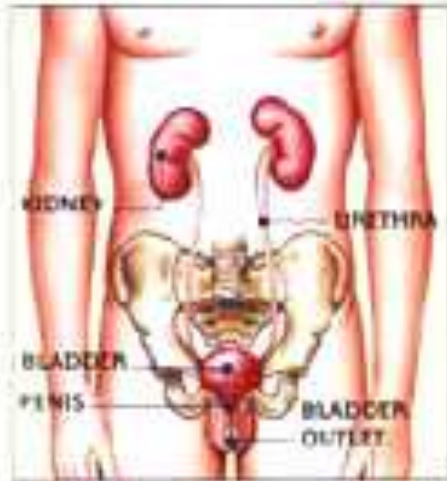
Female pelvic organs



The Continence Foundation
 307 Horton Square,
 16 Bubbwies Gardens,
 London EC2N 7PR
 or phone their Helpline
 9.00 am - 8.30 pm, Monday-Friday
 Telephone 020 7831 9831

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Male pelvic organs

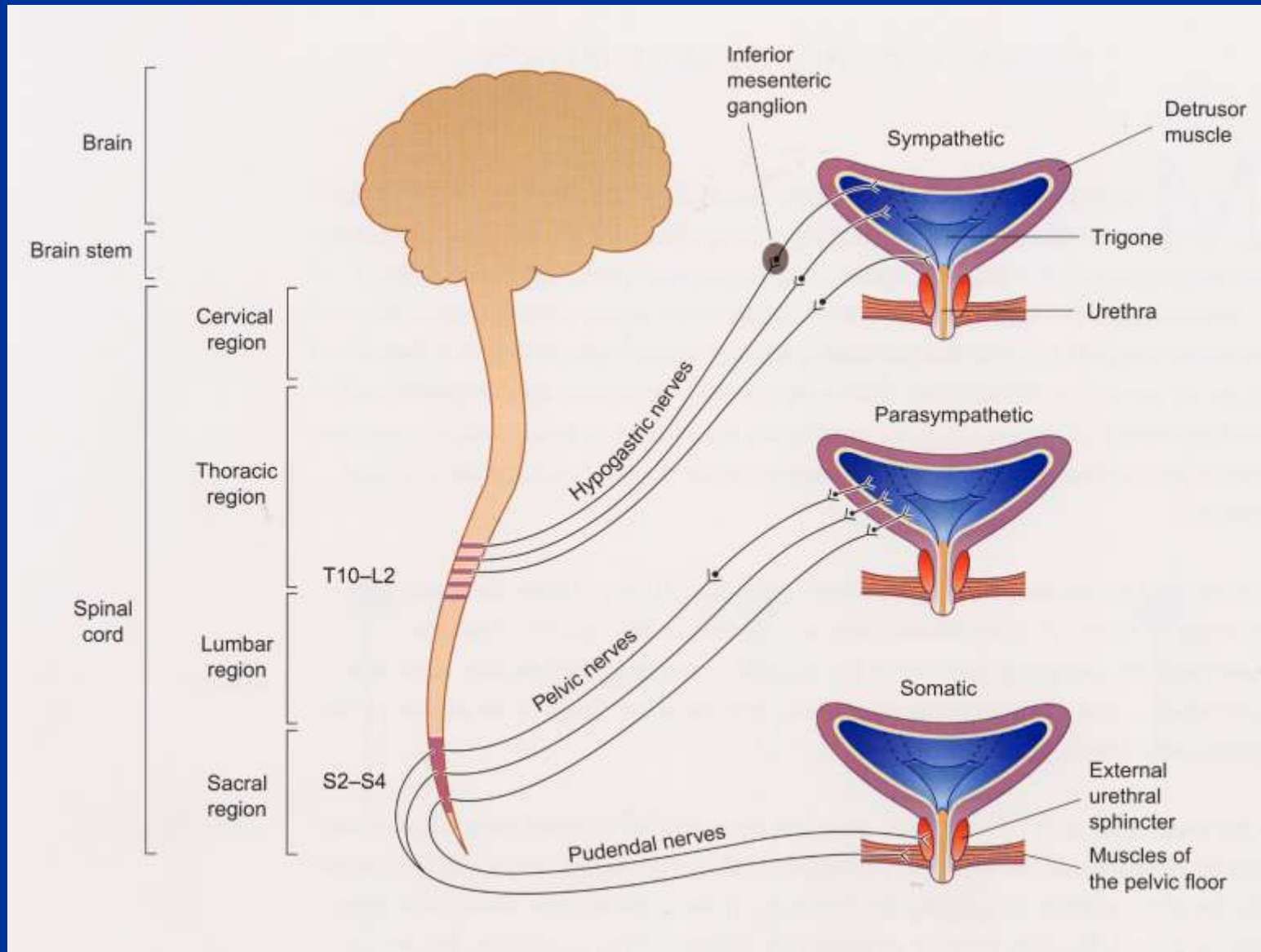


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Neural Control of Micturition



Fluids

Question:

How much fluid do you need every day?

Answer:

1500-2000mls (unless the doctor advises otherwise).
Half the daily fluid intake should be water.



SEM inside an empty bladder



The effect of ageing on the bladder and bowel

- bladder becomes smaller. < elastic tissue
- pass urine 6-8 times per day
- wake 1-2 times per night to pass urine
- increased risk of UTI
- bladder more irritable and overactive (poor contractility)
- increased risk of constipation

Definition of Contenance

Contenance is the ability to pass urine and faeces voluntarily in a socially acceptable place.

To be continent you must be able to:

- RECOGNISE → the need to pass urine/faeces
- IDENTIFY → the correct place in which to pass urine/faeces
- REACH → the correct place in which to pass urine/faeces
- HOLD → on until you reach that place
- PASS → urine/faeces when you get there

The person with dementia may have problems with any of the above

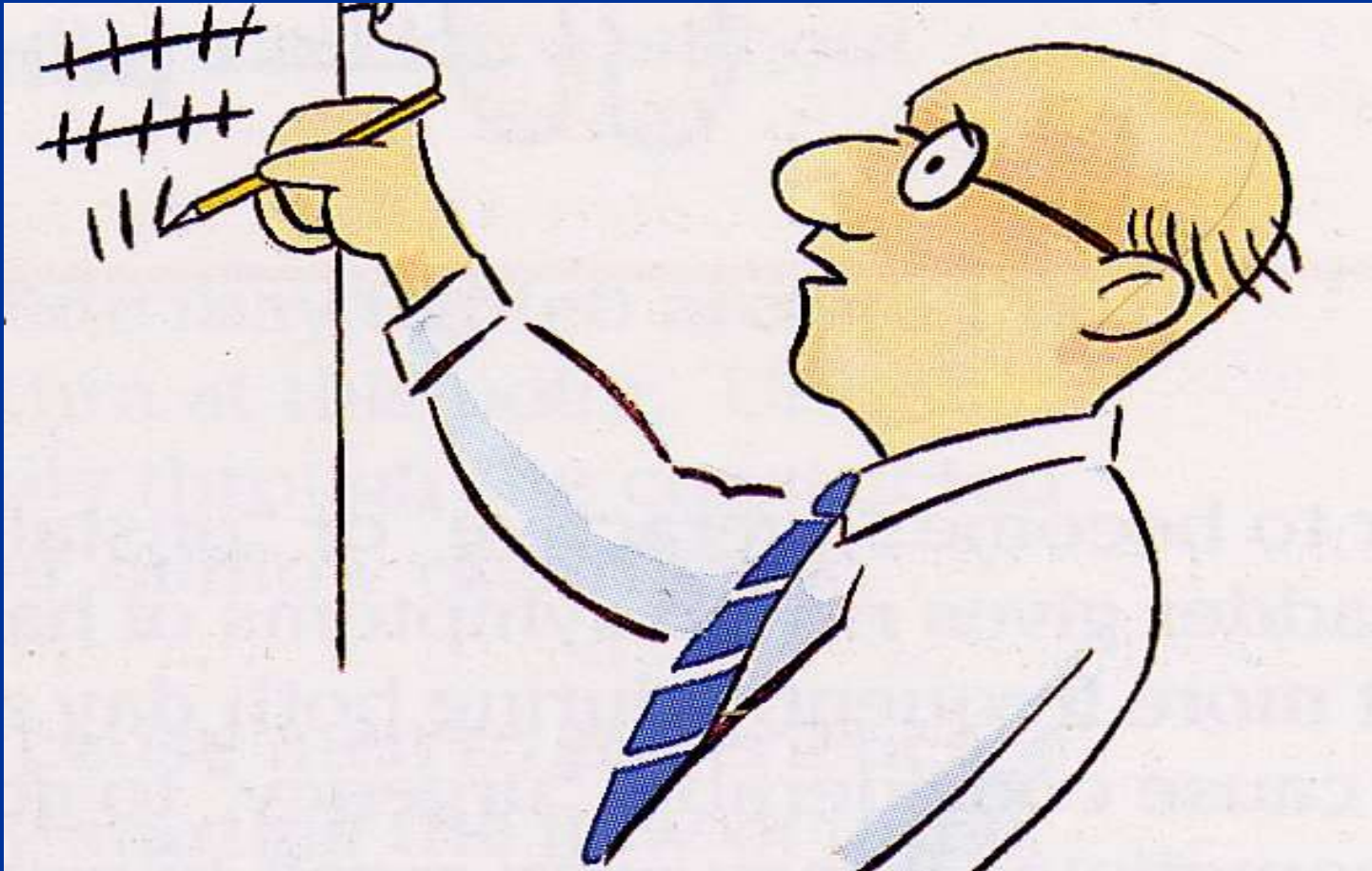
Incontinence

 Incontinence is always a symptom of an underlying problem.

Accurate assessment is the key.

Types of Bladder Problems

Frequency



Urgency



Urinary Tract Infections

- Prevalence
- Causes
- Risk factors
- Assessment - dipstick, MSU
- Treatment – simple
 - specialised

Causes of UTI

- Lack of fluid intake (reduced thirst / fear of incontinence)

Faecal contamination from:

- Poor toilet hygiene – not wiping from front to back
- Not washing hands after voiding or bowels opened
- Poor infection control practices
- Incorrect pad usage
- Faecal incontinence

Symptoms of UTI

- pain passing urine
- frequency
- waking at night to pass urine
- pain above the pubic bone
- occasionally blood in the urine and fever
- urine may be offensive and may contain pus, making it appear cloudy

Non typical symptoms of UTI (more common in frail people)

- falls
- immobility
- confusion
- general poor health
- incontinence,
- perianal area may become excoriated

People with Dementia are susceptible to other causes of incontinence

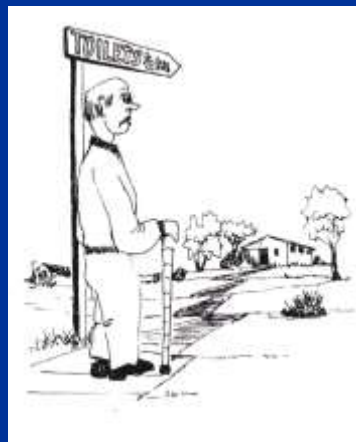


Stress

Urinary retention (Overflow)



Urge



Functional

Stress Urinary Incontinence

Involuntary loss of urine associated with physical exertion (coughing, laughing, exercising or sneezing)

Causes:

Ineffective urethra (bladder tube) due to:

- Pelvic floor muscle weakness
- Pelvic nerve damage following hysterectomy or prostatectomy
- Hormone deficiency
- Constipation

Oestrogen deficient urethra

(a) Side view



(b) Cross-section

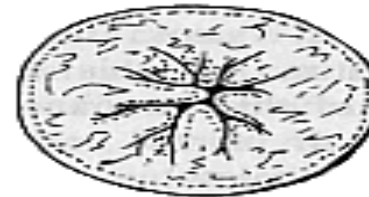


Figure 11.1 *Well-oestrogenated urethra (note interdigitating folds giving efficient closure).*

(a) Side view



(b) Cross-section



Figure 11.2 *Oestrogen-deficient urethra.*

Causes of urge urinary incontinence

- Urinary tract infections
- Secondary to obstruction
- Neurological disease
- Medicines e.g. diuretic therapy
- High caffeine/alcohol intake
- Hormone deficiency



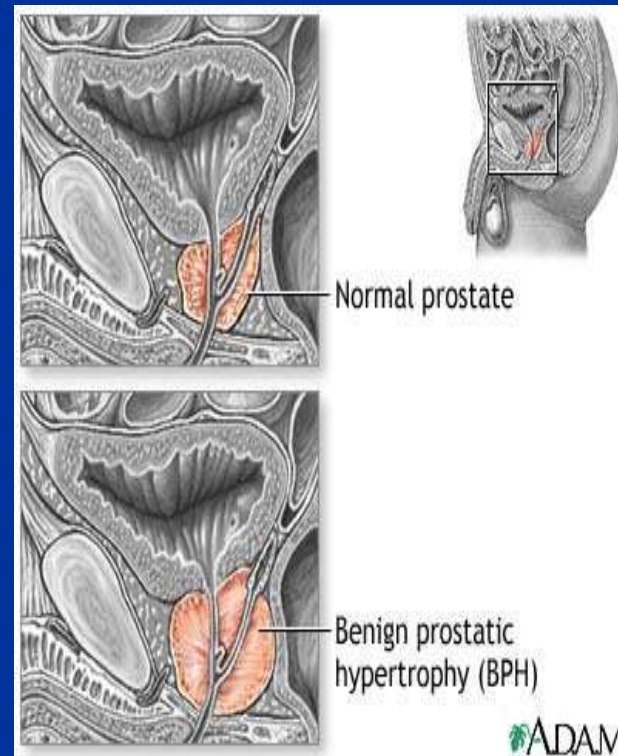
Causes of retention with overflow incontinence

Symptoms

■ Dribbling, poor stream, hesitancy, nocturia, post micturition dribble

Causes:

- Prostatic Enlargement
- Urethral Stricture
- Faecal Impaction



Atonic bladder

Inability to empty the bladder effectively

Causes

- Diabetic neuropathy (this is often overlooked).
- Dementia
- Overstretch injury of the bladder (residents who have been hospitalised eg # NOF are at risk)

Dexterity

- Ability to adjust clothing
- Ability to attend to hygiene
- Ability to use aids and appliances

Mobility

- Ability to reach toilet on time
- Ability to get on/off the toilet

Falls risk

- Postural hypotension (eg Parkinsons)

- Nocturia

- Urgency/urge incontinence

 - rushing to the toilet

 - risk of slipping on wet floor

- Other falls risks – eyesight, environment, medicines etc

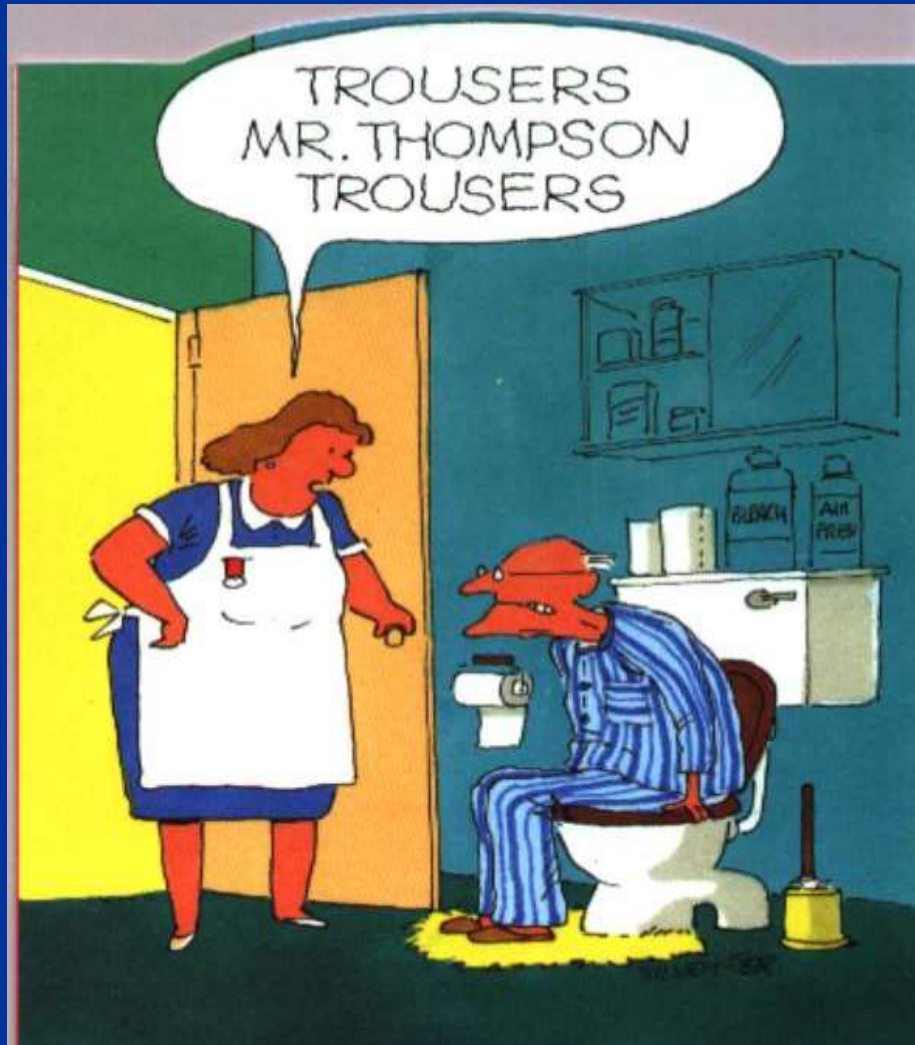
Incontinence rates in aged care facilities (USA)

- % of incontinence in those who
 - dress themselves 20%
 - dressed by nurses 50%
 - walk with walking stick 18%
 - depend on walking frame 39%
 - confined to wheelchair 62%
 - confined to bed 67%

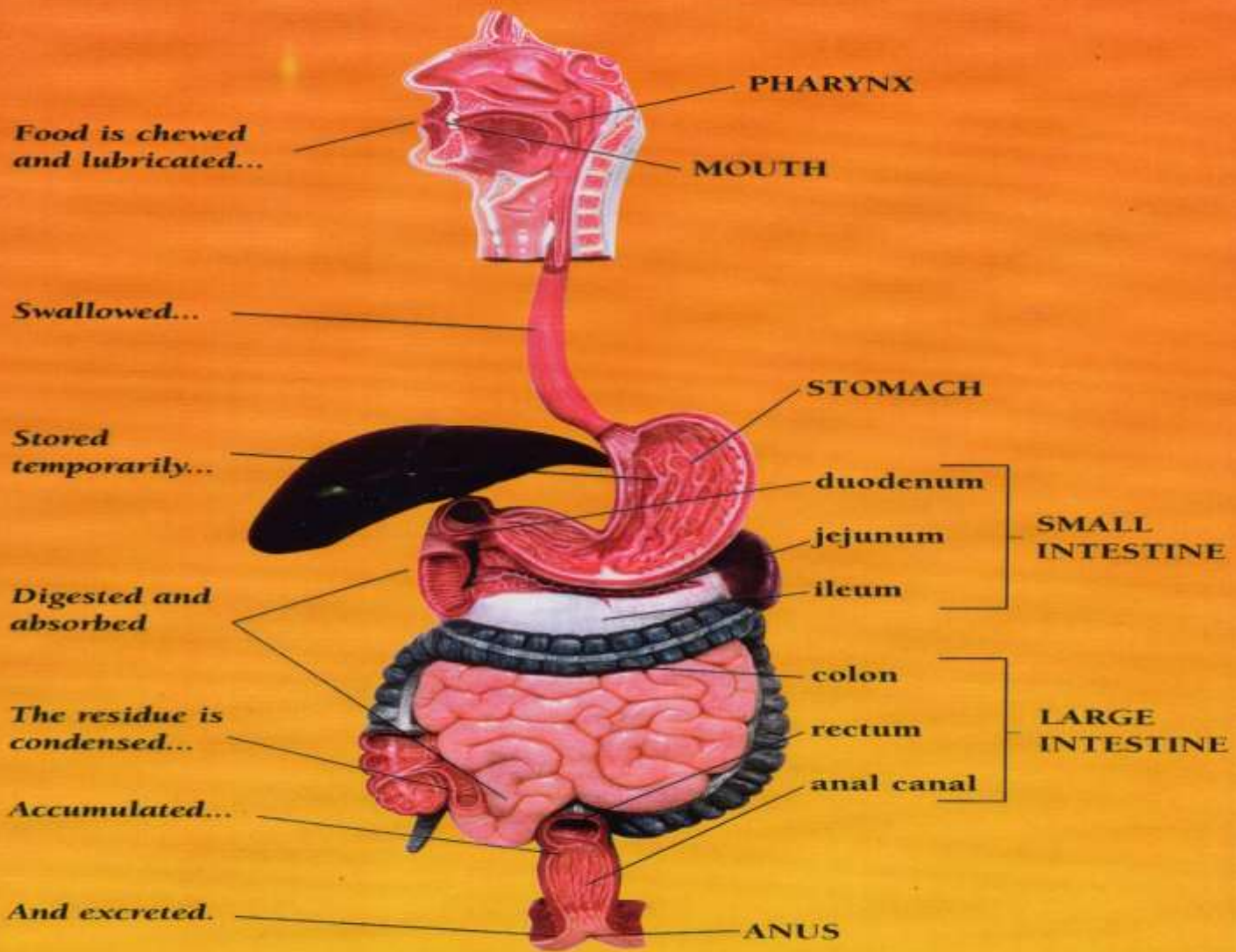
(Source and date unknown)

Impact of dementia

- STML – frequent urination
- NB:– prostate enlargement, UTI etc
- Inability to recognise the need to go to the toilet
- Knowing when the bladder/bowel is empty
- Inability to find/recognise the toilet .Urinate in inappropriate places
- Difficulties managing clothing










THE DIGESTIVE TRACT



Normal Bowel Function

- “ Normal” bowel activity ranges from the bowels being opened 1-3 times per day to once very three days
- Stools/ motions should be soft, formed and easy to pass
- Bowel empties in 20 -30 seconds
- Pain and /or straining should not occur

THE BRISTOL STOOL FORM SCALE

<i>Type 1</i>		Separate hard lumps, like nuts (hard to pass)
<i>Type 2</i>		Sausage-shaped but lumpy
<i>Type 3</i>		Like a sausage but with cracks on its surface
<i>Type 4</i>		Like a sausage or snake, smooth and soft
<i>Type 5</i>		Soft blobs with clear-cut edges (passed easily)
<i>Type 6</i>		Fluffy pieces with ragged edges, a mushy stool
<i>Type 7</i>		Watery, no solid pieces ENTIRELY LIQUID



Definition of Constipation

- Stools are hard and dry : Type 1-2 Bristol stool form
- Straining is required to empty bowel
- Bowels are opened infrequently (This varies between individuals)

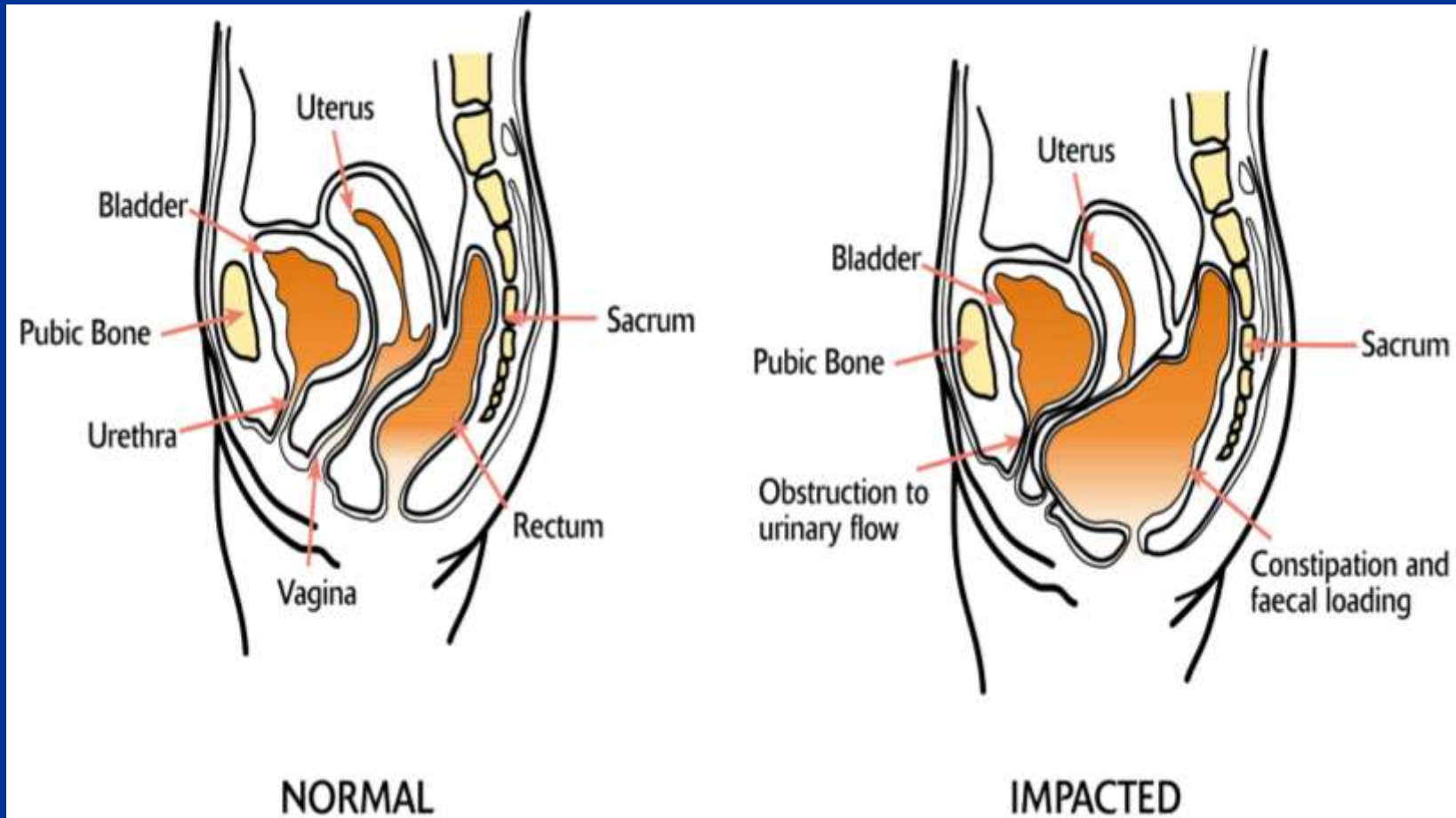
Causes of constipation

- Inadequate fluids, fibre, physical activity
- Oral health issues
- Effects of medications can be constipating e.g. codeine, many pain killers, antihypertensives, iron tablets, aluminium antacids eg: Mylanta
- Many other physical and psychological causes

Bowel Problems

-  Anal incontinence - inability to control passing wind
-  Faecal incontinence
 - overflow incontinence
 - neurogenic incontinence
 - inflammatory causes

Faecal Impaction



Medicines



Drugs and medicines may aggravate/cause incontinence

- Caffeine, alcohol
- Over the counter medicines
- Medicine/drugs that affect mobility
- Medicines that aggravate/cause constipation
- Medicines that have a direct effect on the urinary and digestive tract
- Miscellaneous



Common drugs that can cause or aggravate incontinence in the elderly

- Sedatives and hypnotics – contribute to falls – Temazepam and tricyclics
- Diuretics –frequency, urgency, increased urine production - Lasix
- Antidepressants – sedation, constipation, confusion and urinary retention- Amitriptyline and Dothiepin
- Tranquillisers – constipation, confusion, immobility – Haloperidol and Chlorpromazine



The Good News

70% of people will have their incontinence cured or made significantly better by conservative measures such as:

conservative measures such as:

- attention to fluid intake and diet
- bladder and /or bowel retraining
- and exercises.

Continence assessment may include the following:

- Identifying that the client/ resident has a continence problem
- A continence chart will help to provide useful information on how the bladder and/or bowels are working
- Interpretation of the continence chart will form the basis of management strategies

Continence Chart





Records how often the person:

- Goes to the toilet and /or wets
- How many pads they use
- How much and what they had to drink
- Records the pattern of toileting and /or wets
- Should include non verbal clues as pulling on clothes, agitation, getting up and down
- How often they open there bowels, type of stool

Management options

- Treat underlying cause
- Change of medications
- Fluids
- Diet
- Timed/flexible toileting
- Deferment techniques
- Environment

Fluids

-  Offer 6-8 drinks per day (unless the doctor advises otherwise)
-  Limit caffeine drinks – tea, coffee
-  Limit alcohol
-  Limit citrus beverages

Risks associated with poor fluid intake

- Increased concentration of the urine
- Increased risk of UTI's
- Bladder irritation resulting in urgency and frequency
- Orthostatic hypotension which may increase risk of falls
- Confusion / disorientation
- Lethargy, drowsiness
- Constipation and faecal impaction

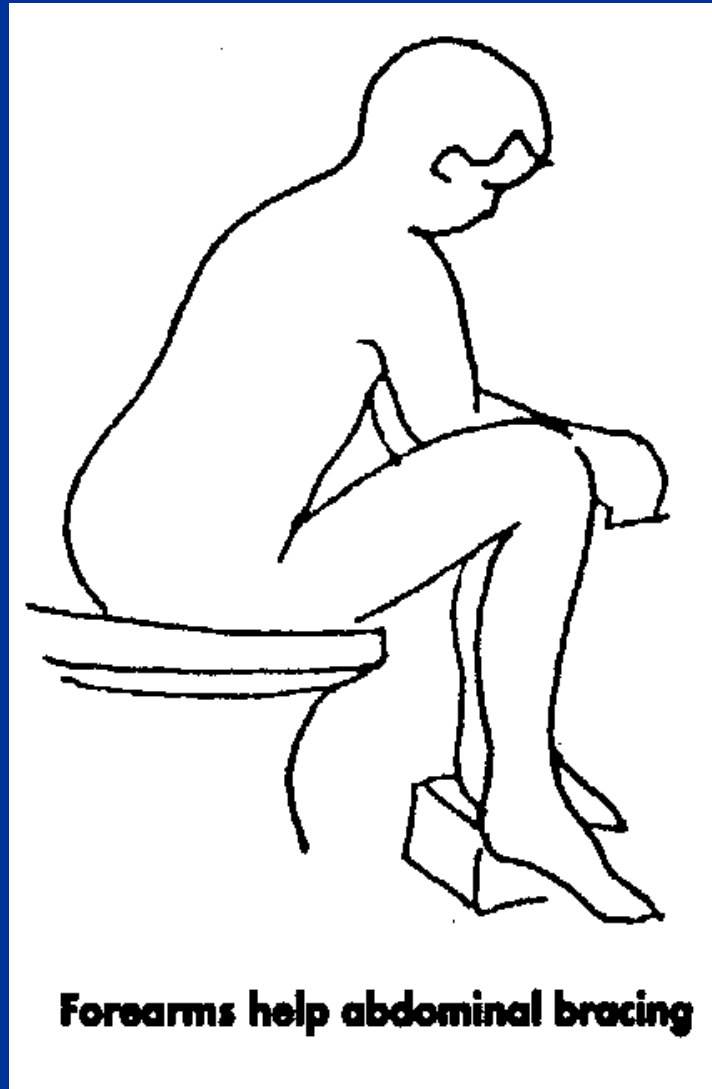
Ways to increase fluid intake

- NB : Always check first that this is appropriate
- Offer a small drink each time you attend to the resident
- Offer water or juices as an alternative to tea or coffee
- Soup, jelly and water melon will also boost fluid intake
- Make drinks look attractive
- Offer water in between times

Good bladder and bowel habits

- Drinks 8-10
- Dietary fibre – balance of insoluble and soluble fibre
- When in toilet, give client glass of water or run tap.
- Remind them why they are there
- Double void
- Correct toilet position
- Taking client at regular times, often after meals depending on chart times and urge to defecate
- Reminding client to wipe ‘front to back’

Toilet position



Fixed/timed toileting

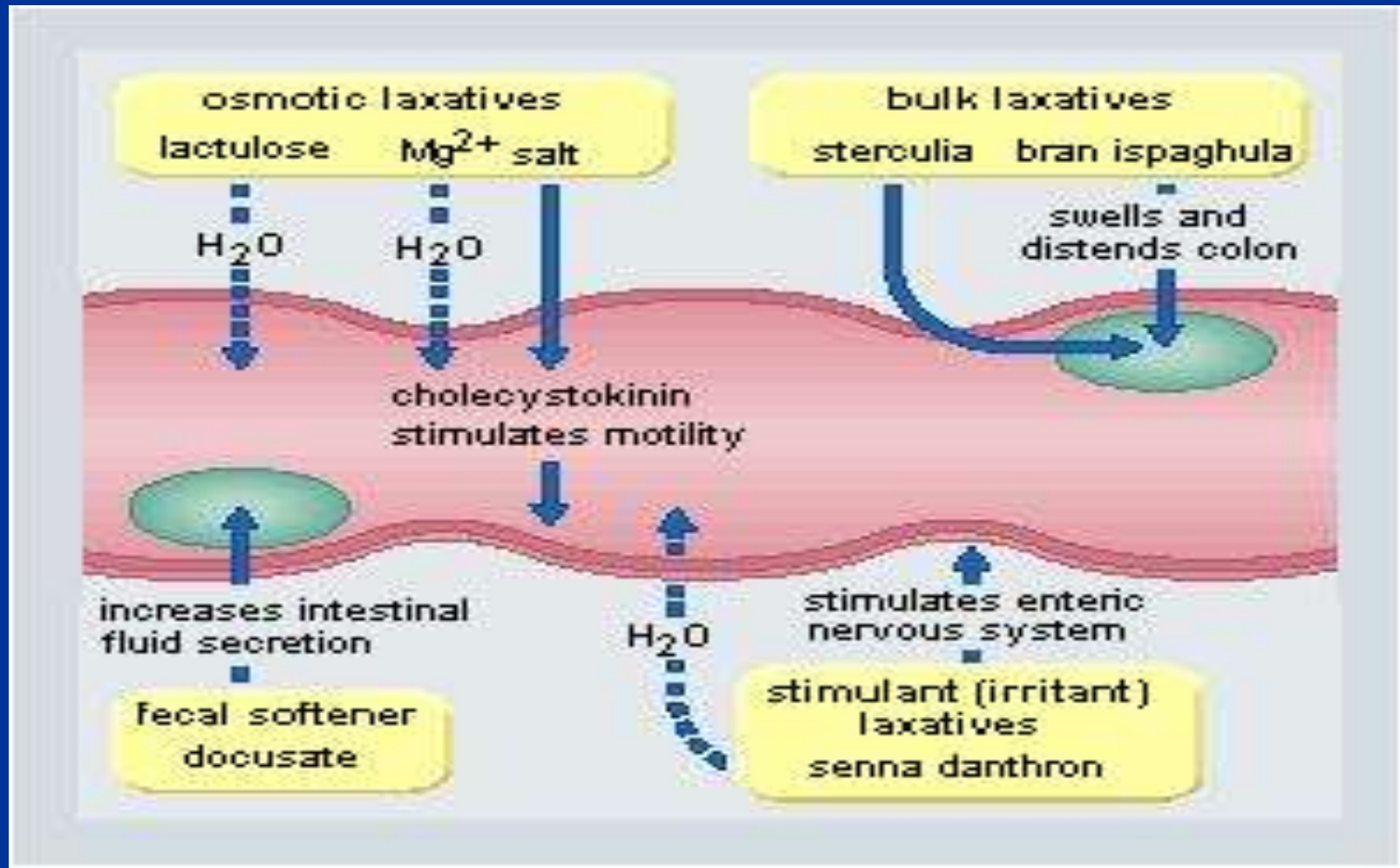
- For those with poor mobility, memory
- Timed toileting will depend on the pattern shown on bladder chart minus 30minutes

Plan:

Set up a timed toileting schedule at 6.30, 9.30 and 12.30 for the resident

Times	Drink	Toilet	Wet
7am	Cup tea	asked	wet
10am	Cup coffee	asked	dry
1pm	water	asked	wet

Appropriate use of laxatives.



Clothing

Encourage the wearing of clothing that is
easy to adjust:

eg Velcro ® on clothing, avoid zips
and buttons

Challenging behaviours

- Void/defaecate in inappropriate places
- Why is this behaviour occurring?
- Inappropriate removal/destruction of products
- Pads flushed down toilet

Assess the environment

- lighting (consider functional incontinence) – night light
- distance to the toilet (exercise tolerance/ fitness)
- Keep the toilet clear and free of clutter
- Toilet acceptability eg privacy, cleanliness, odour
- height of toilet (is a raised toilet seat required?)






Lack of colour contrast can cause confusion for people with dementia



Tips on boosting contrast to aid vision for people with dementia

- Signage – distractions in the toilet – soap, paper towel dispenser, mirror (Namazi and Johnson 1991)
- Install door knobs which contrast with the doors.
- Install a motion detector to activate lighting to avoid having to enter a dark room to find a light switch. (Grover C. Gilmore 1991)

Assess skin condition

-  Fungal infections
-  Prolapses
-  Talcum powder is not recommended
-  Some creams affect pad absorbency
-  Use of barrier creams may be appropriate

Product management



Appliances : (pads, drainage sheaths, catheters, urinals)

- Always a last resort
- Need to be individualised
- Seek assistance from continence adviser

Management of incontinence

- Assist resident to regain continence where possible
- Assist resident to be continent with assistance from staff
- Maintain resident's comfort and dignity through providing aids and equipment to provide social continence

Incontinence aids and appliances

- Important for social continence
- Maintain skin integrity
- Allow people to participate in their community
- Are expensive

Incontinence pads and protective equipment



Absorbent pads



Dribble pouch



All-in-one briefs



Chair and bed pads

Anatomical pad



Pull up pants



Continence Advisory Service of WA

All in ones



Continence Advisory Service of WA

Reusable products

 Washable
underwear



 Body stockings

Product demonstration

Continence Subsidy Schemes

- CAAS - Continence aids assistance scheme
- CMAS – Continence management advice service
- Both schemes available for those clients in low care facilities

Questions



Waterworks Week March 15 -21

■ Posters and resources available

■ Water Works III Art Award and
Exhibition March 17 – 29 Atwell
Gallery, Alfred Cove



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Continence Advisory Service of WA

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