

WHERE IS THAT TOILET?



CONTINENCE AND DEMENTIA – WA DTSC

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Session Aims

- Improve continence care for those with Dementia:
 - Cognition and the impact on toileting
 - Assessing the continence problems
 - Challenging behaviours and toileting
 - Environmental changes to promote continence
 - Practical strategies to support the person with dementia and continence

Prevalence dementia and incontinence

Dementia

- 332,000 people in Australia in 2014
- Rates doubles every 5yrs over 65yrs
- 1:4 over 85years

DOHA 2010/ ALZHEIMERS

Incontinence

- 1:5 or 24%population
- 53% dementia & incontinence , compared to 13% without dementia
- Estimated 80-90% urinary and/or faecal incontinence in people with Dementia
- One of top 3 reasons for being admitted to residential care

AJHW2006, Hawborn 2006, Aminoff, 2008

Urinary Incontinence

International Continence Society

Involuntary loss of urine that is a social or hygiene problem

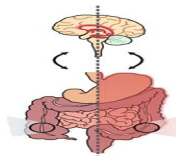
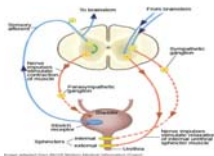
Age related changes contribute to UI in frail elderly persons

Abrams et al, 2009 ICI

Aged related changes	Potential effects on Continence
Muscle degeneration	Bladder overactivity and urgency UI
Bladder - Decreased bladder capacity and contractility Detrusor overactivity Increased residual urine	Increased urinary symptoms and UI
Urethra- decreased closure pressure in women	Increased Stress urinary incontinence (SUI) + urgency
Prostate – benign obstruction and > Prostate Ca	urinary symptoms and UI
Decreased oestrogen	Atrophic vaginitis, urgency and UTI
Increased urine production at night	Nocturia and nocturnal incontinence
Altered central and peripheral neurotransmitters action	lower urinary tract dysfunction

Continence is maintained by:

- Interpreting and responding to the sensation of a full bladder and bowel
- Being able to inhibit the passage of urine and/or stool
- Pass urine/faeces when you get there and empty to completion



Components of 'Going to the toilet'

CCDA & CFA 2012



Cognition and toileting

Involves planning

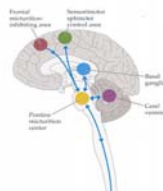


- Recognise the need
- Hold on till it is appropriate to go
- Find the toilet
- Recognise the toilet
- Forget how to unfasten their clothes
- Forget what to do when you get their



Types of Dementia and Incontinence at earlier stage

- Normal pressure hydrocephalus- gait apraxia and incontinence
- Vascular dementia – damage to frontal subcortical circuits
- Frontal temporal dementia - damage to cortical inhibitory centre for micturition
- UK study found- MMSE < 23 (Mild cognitive impairment) had UI



Contributing Factors toileting

Agnosia – Visuospatial impairments

- Misperception of the toilet – urinate on floor
- Can't sit on toilet without help
- Frightened of mirror in bathroom.



Contributing factors toileting

Apraxia

- Lowering a zip
- Removing/ pulling down pants
- Series of movements to sit on the toilet
- Not wiping



Understanding difficult behaviours

Behaviour	Possible Cause
Angry, Agitation, Disruptive, Restlessness, pacing, tugging on trousers	Constipation Want to go to the toilet urgently Distressed by the incontinence
Wandering	Thirsty, Hungry
Hallucinations, Paranoid	UTI or impaction, dehydrated
Passive incontinence – no attempt to toilet	Depression, Apathy, over dependence

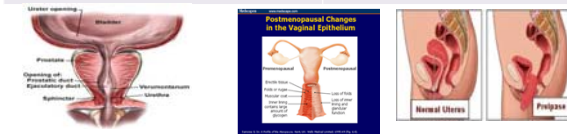
Exclude reversible causes of UI

- Hydration – too much, too little
- Delirium
- Infection
- Atrophic vaginitis
- Psychological causes – depression
- Pharmaceuticals – sedatives, diuretics, opioids
- Endocrine – thyroid, diabetes
- Restricted mobility
- Stool – constipation or impacted



Underlying Cause of incontinence

Dysfunctional Voiding	Over Active Bladder(OAB)
Obstruction <ul style="list-style-type: none"> • Constipation • Enlarged prostate Sensation <ul style="list-style-type: none"> • Dementia • Diabetes 	<ul style="list-style-type: none"> • UTI – Infection • Obstruction • Atrophic Vaginitis • Prolapse
Results in poor voiding, hesitancy, urinary tract infections, nocturia, >residual urine	Frequency, urgency with/or without urge leak



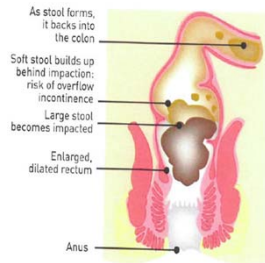
Evaluate Cause and treat where appropriate

Enlarged Prostate	Minipress, Flowmaxtra Finasteride, Duodart Refer urologist
Atrophic Vaginitis	Topical Oestrogen – Vagifem, Ovestin cream
Prolapse	Pessary – refer Gynaecologist Weight Loss Treat constipation
Residual urine	Double void- sit down try again, supra pubic pressure over bladder Turn on taps

Bowel function and dementia

Person with severe cognitive decline:

- Loose ability initiate defecation voluntarily
- Defer the urge
- Water is removed from stool = Constipation
- Not empty properly > Faecal impaction > spurious diarrhoea
- Medications for dementia- Donepezil, Galantamine can cause diarrhoea



Bowel function and dementia

Increased Confusion due to:

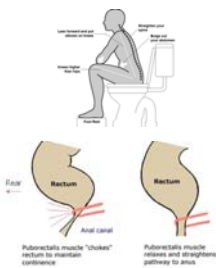
- Pain and discomfort of hard stool, bloating and nausea
- Increased restlessness, agitation and aggression
- Parcelling, concealing faeces
- Manual removal



Continence Advisory Service of WA

Initiating good bowel habits from bowel chart

Caution if Total Hip replacement



Work with gastro colic reflux:

- Diet with adequate fibre
- Hot drink
- Exercise - walk , abdominal massage
- Sit on toilet 30 minutes later
- Good position
- Assess and relieve constipation

Best practice recommendations to minimise functional decline (AHMAC 2004)

- Assess residents on admission for urinary and faecal incontinence
- * Assess risks for Transient urinary and faecal incontinence
- * Maintain hydration
- * Modify environmental factors
- * Encourage mobilisation and activity
- * Consider specialist assessment re appropriate interventions.

Brightwater & Continence Advisory service of WA, n 2014

Assessment – 3 objectives

- History- medical, surgical, function, cognition, mobility, dexterity, medications
- MSU
- Bladder or bowel diary
- Bladder scan (Ultrasound)

• *Determine the need for further investigation*

• *Developing a management plan*

Ouslander,2000

Brightwater & Continence Advisory service of WA, n 2014

Case Study 1

Bill is an 85yr old man just admitted to ACF. Incontinent at home prior to admission, with wife stating he had been wetting chair, had refused to wear a pad at home. History - Alzheimer's disease, Prostatectomy 4yrs ago. Medications – Coloxyl and senna, for bowels, pm. Smearing seen on pad, type 2 stool.

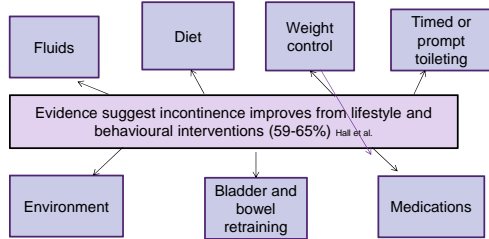
Day	Time	0000	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400	1500	1600	1700	1800	1900	2000	2100	2200	2300
1	Intake							180ml		150ml				sips			150ml								
	Output		PW	**					PW	**		wet			P.W	**			A	W		BO	small	P	
2	Intake							180ml		150ml		150ml					150ml								
	Output		P.W	**					P.W	**		A	W			P			wet						P
3	Intake							150ml				180ml		sips			180ml								
	Output		P.W	**								W	**			P				A	W				P

Complete grid using the following codes:
 O = Went to the toilet on their own
 D = Resident is dry and checked
 A = Resident asked to be toileted
 T = Resident cannot ask, and nurse takes to toilet
 V = When resident voids in commode or toilet
 I = Inappropriate voiding
 W = Resident is wet, specify + Damp/wet underwear
 ** = Wet external clothes
 *** = Wet linen/clothes/furniture
 P = Pad is changed
 BO = Bowel opened
 BI = Incontinent bowel episode

Analysis of Chart
 Frequency Day: 5
 Night: 7
 Level of Wetness: pad
 No of pads: 4

Management

Behavioural modifications to improve function and quality of life



Prompted voiding strategy



- Focus the person attention –“Are you wet or dry? ”
- Check for wetness – give feedback
- Ask if they would like to use toilet- prompt 3 times
- Toilet if respond positively
- Positive feedback for dryness and toileting
- Offer fluids and remind time of next toileting

Timed/ Scheduled toileting Strategy



- ICS 2009 Incontinence r/t comorbid functional conditions (impaired cognition and mobility limits the ability to toilet)
- Regular toileting assistance
- Based on clients individual bladder chart, adjust by 30mins
- ACFI 5 – Continence .
- Documentary evidence of incontinence prior to program

Communication

- Simple step by step instruction

Watch non verbal clues – pulling at clothes, flushed face, agitation

- Use words that are familiar to the person “pee”, “wee”
- Do not rush the person
- Validation of thoughts and feelings



Incontinence and environmental modifications

- Picture clues - name (toilet, rest room)
- Signs- yellow background/ blue letters or
- Arrows on floor
- Colour contrast between toilet and floor
- Remove distracting objects - mirror, soap holder, towel dispenser
- Light on at night in bathroom
- Keep pathway toilet free of clutter, door open
- Easy manageable clothing

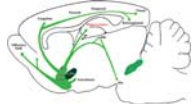


Falls and incontinence, 36.8% related to toileting (Thompson 2007)
 Improving mobility and toileting skills, 37.7% reduction in urine loss

Antimuscarinic/Anticholinergic drugs for Over active bladder (OAB) and the effect on cognitive function

- Oxybutinin
- Darifenacin (Enablex) blocks M3
- Solifenacin (Vesicare) M3
- Tolterodine

Cholinergic transmission process- memory, visuospatial, language skills



- Anticholinergics – M3 receptors (Solifenacin and Darifenacin) less penetration of blood brain barrier (Kay et al,2005)
- Darifenacin had no significant effect on cognitive function (Lipton,2005)
- Dual use of cholinesterase inhibitors and anticholinergic- Oxybutinin and Tolterodine appear to show greater rates of functional decline (Sink,2008)

Watch this space

- Mirabegron –
beta.adrenoreceptor agonist for OAB
- Induces detrusor muscle relaxation
- No impact on strength of detrusor contraction during voiding
- Potential – less impact for those with cognitive impairment, less dry mouth



Which product would you choose and why?



Continence Advisory Service of WA

Continence Advisory Service

- Telephone: 9386 9777
Country callers 1800 814 925
- Email: info@continencewa.org.au
- Website: www.continencewa.org.au
- Resource centre & product display room:
Hollywood Private Hospital,
Monash Avenue, Nedlands

Questions



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