



MONASH
University

For healthcare professionals

10 Guiding principles

to support the safe and appropriate use of medication for the management of **urinary incontinence** in **people living with dementia**





Urinary Incontinence

is a distressing and often stigmatised condition that impacts quality of life for individuals living with dementia.

Non-medication management is the preferred first line approach for urinary incontinence. The decision to use medication can be complex and there is limited evidence to guide the use of medications for people living with dementia.

Safe and appropriate use of medication is best supported using a shared decision-making approach at every step, ensuring involvement of the person living with dementia and their carers, as appropriate.

Managing urinary incontinence, including prescribing or deprescribing medications, requires a multidisciplinary care team (e.g., general practitioners, geriatricians, urologists, nurse practitioners, nurses, pharmacists, aged care staff and other allied health professionals) – each contributing within their scope of practice to support person-centred care. Throughout this resource, we use the term ‘healthcare professional’ to refer to the range of people who may be involved in the multidisciplinary care team helping to manage urinary incontinence.

Given the complexity of decisions surrounding medication management of urinary incontinence in people living with dementia, it is important that healthcare professionals ensure that the individual and their carers feel informed, supported and empowered throughout the decision-making process.

How to use the resource

These Guiding Principles aim to guide you as the healthcare professional to engage with individuals and carers, explore treatment goals and weigh potential benefits and harms of starting, continuing and stopping medication for urinary incontinence. These Guiding Principles are informed by the lived experiences of individuals living with dementia, their carers and multidisciplinary healthcare professionals managing urinary incontinence.



You may wish to provide your patients with a copy of the consumer version of these 10 Guiding Principles, to support ongoing conversations and shared decision making.



Quotes from those who helped shape this resource are included throughout.

Guiding Principles

This page provides an overview of the ten Guiding Principles. The rest of the resource will walk you through each Guiding Principle in more detail.

#1

Consideration of urinary incontinence type and contributing factors is important to guide the decision-making process of choosing the most appropriate medication to manage symptoms.

#2

Individualised treatment goals for the management of urinary incontinence should be discussed and documented.

#3

Non-medication strategies for urinary incontinence should be trialled before medications and continued alongside medications.

#4

Shared decision making should be utilised to identify the urinary incontinence medication that most aligns with goals of care.

#5

Treatment expectations should be discussed and documented.

#6

Medication for urinary incontinence should be started at a low dose and date of next review should be planned in advance.

#7

Information about urinary incontinence medication should be provided in an appropriate format.

#8


Medication for urinary incontinence should be monitored to ensure meaningful, person-centred benefits and ongoing need.

#9

Medication for urinary incontinence should be proactively monitored for potential harms to guide ongoing use.

#10

Medication for urinary incontinence should be regularly reviewed and deprescribed as appropriate.



Guiding principle

#1

Consideration of urinary incontinence type and contributing factors is important to guide the decision-making process of choosing the most appropriate medication to manage symptoms.

Prior to considering using medication to manage urinary incontinence, healthcare professionals together with the person living with dementia and/or their substitute decision maker, should correctly identify the type of urinary incontinence that is being experienced.

There are many different types of urinary incontinence (e.g., stress, urge or functional urinary incontinence) and some individuals may experience multiple types of urinary incontinence. Some medications are only indicated for certain types of urinary incontinence.

When new or worsening symptoms of urinary incontinence emerge, healthcare professionals should investigate and address potential contributing factors such as:

- current medications (e.g., anticholinesterase inhibitors, diuretics or SGLT2 inhibitors)
- existing conditions (e.g., urinary tract infections, progression of dementia, constipation)
- mobility
- lifestyle factors (e.g., fluid intake, physical activity)
- behavioural changes (e.g., refusal to use toilet)

The mnemonic DIAPPERS (Delirium, Infection, Atrophic urethritis/vaginitis, Psychological, Pharmacological, Excessive urine output/endocrine disorders, Restricted mobility, Stool impaction) may be useful to identify potentially reversible causes of urinary incontinence.¹

The type of urinary incontinence, contributing factors and steps taken to address these factors, should be documented in the person's medical record.



“Well, the most important thing, I think, is that you don't put them [person living with dementia] into urinary retention [incomplete bladder emptying]. So, you've got to have done a workup, and you've got to know what incontinence you're dealing with, and you've got to have a sense of how the bladder works... really, the starting point is getting the diagnosis of the right kind of incontinence.”

- Prescriber

“We look at what medications they're [person living with dementia] on as well, because, as you know, certain medications can affect urinary incontinence, and the frequency [of urinary incontinence symptoms] as well... their past history is significant, and ambulation [mobility] all those sorts of things.”

- Continence nurse

1. Khandelwal C, Kistler C. Diagnosis of urinary incontinence. *Am Fam Physician*. 2013;87(8):543-550.



Guiding principle

#2

Individualised treatment goals for the management of urinary incontinence should be discussed and documented.

Healthcare professionals should engage in a comprehensive discussion with the person living with dementia and/or their substitute decision maker, about how the person would like to manage their urinary incontinence symptoms and their specific treatment goals.

Treatment goals may vary between individuals and may change over time for individuals. Treatment goals could include reducing leakages, improving sleep quality by reducing the frequency of night urinations, or improving comfort and confidence during social activities. Aiming for complete resolution of symptoms may not be realistic; thus treatment should aim to support outcomes that are meaningful to the individual such as improvements to quality of life.

The discussion about treatment goals should be clearly documented and may include other relevant members of the healthcare team and caregivers.



“I prefer to go on the goals. What they [person living with dementia] specifically have come to achieve. Some don’t actually want treatment... They just want containment and funding... I do try and keep it very goal focused in that aspect because they’ve already got so many things going on for them.”

- Continence nurse

“So, in the beginning [early stages of dementia], they’re [person living with dementia] moving around... having to go to the shops, the doctors and so they’re hopeful at that time for the efficacy of the medication and may be able to tolerate anticholinergic [medication side] effects.”

- Pharmacist



Guiding principle

#3

Non-medication strategies for urinary incontinence should be trialled before medications and continued alongside medications.

Medications to manage urinary incontinence should only be considered after person-centred, non-medication strategies (e.g., behavioural strategies, continence care products) have been trialled for an adequate and agreed length of time and have not met the goals of care. The recommended length of time will depend on the specific strategy and the individual, and should be communicated to the person living with dementia and/or their substitute decision maker to ensure treatment plans and expectations are clear.

If a medication is started, non-medication strategies should still be implemented alongside medications in the management of urinary incontinence.



“We would ask them [person living with dementia] whether they can give us a chart to identify whether they are able to manage through behavioural modifications or other strategies ... If all these strategies fail and the client’s goal is not met, then based on their cognitive capacity and considering other factors, we recommend medication management.”

- Continence nurse

“[Before starting medication we consider] have we really stuck to the toileting times or not? Or if somebody’s asking for coffee at 8 o’clock in the night, are you giving them [person living with dementia] coffee? So just things like that, just those little changes, I think make a huge difference.”

- Aged care nurse



Guiding principle

#4

Shared decision making should be utilised to identify the urinary incontinence medication that most aligns with goals of care.

There are multiple medications available for the management of urinary incontinence. When considering a medication, discuss the different medication options with the person living with dementia and/or their substitute decision maker.

This discussion should involve shared decision making to determine the medication that most aligns with the individual's treatment goals and their needs, preferences and values. The discussion should include comparing:

- impacts on urinary incontinence symptoms
- potential impacts on cognition
- side effects
- cost of the medication
- medication burden (e.g. number of doses per day)

Additionally, if considering the use of an anticholinergic medication, the cumulative anticholinergic and sedative burden of the person's entire medication regimen should be taken into account.




“From what I’ve learned through my experience of being prescribed medication, asking about side effects, asking about what could this [medication] do? Benefits vs adverse side effects or consequences? I think, talking through what impact it [medication] might have. If it [medication] complements your current medication schedule?... I think several considerations need to happen throughout.”

– Carer



Scan for summary table that compares safety and efficacy of medications



Guiding principle


#5

Treatment expectations should be discussed and documented.

Before starting a medication to manage urinary incontinence, explain and set realistic expectations for treatment with the person living with dementia and/or their substitute decision maker.

Discuss the anticipated time frame to see medication benefits as they relate to the individual's goals of care and time frame for occurrence of potential side effects.

Expectations for treatment and anticipated time frame for benefits should be documented in the medical record.

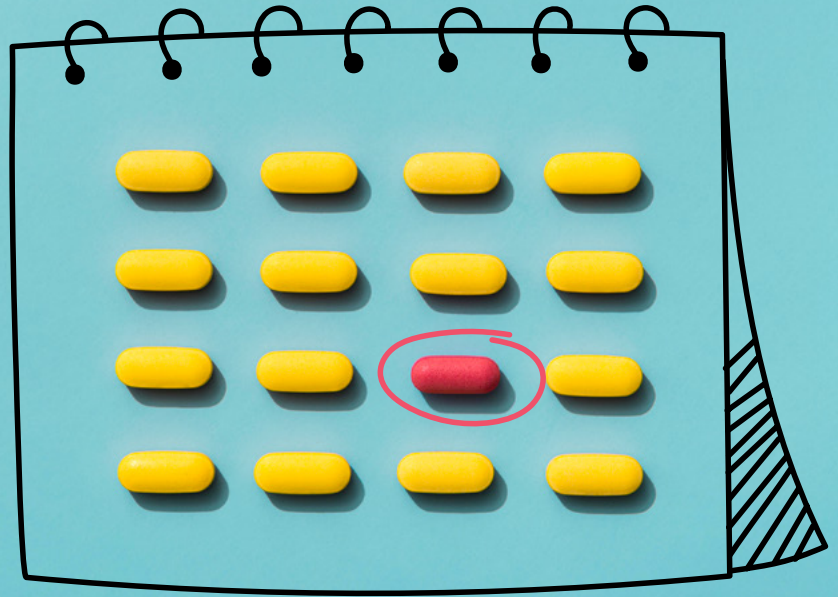


“I think there needs to be a more in-depth discussion of ‘this could happen’. Going through several considerations, making sure you’re confident... making sure that there is a plan B, plan C if things don’t quite work out with that medication and I guess to feel both informed and have expectations of what it [medication] could potentially do in a positive way, but also kind of anticipating what negative consequences could also happen.”

– Carer

“I tell them [person living with dementia] things like if it’s mirabegron [medication for urinary incontinence], that you might see some benefit initially, but we’ll see the maximum benefit within a month. So, we want to look at this in a month’s time to see if [symptoms] have actually improved or not. And if it hasn’t, then it’s not going to work for you.”

– Continence nurse



Guiding principle

#6

Medication for urinary incontinence should be started at a low dose and the date of next review should be planned and documented in advance.

If the decision is made to start a medication for management of urinary incontinence, the initial dose should be low and only titrated upwards if it is well tolerated and only partially achieving the treatment goals.

Review treatment effectiveness and dose every 2-4 weeks during titration and monitor closely for new or worsening side effects.

Plan and discuss the date of next review with the person living with dementia and/or their substitute decision-maker and document it in the medical record.



“But I would say that [medications for urinary incontinence] should be trialled, not just to be given it and to go away.... I think it should be trialled – a professional person keeps an eye on them [person living with dementia] for the time that they are using it, [including] what the results are.”

– Carer

“I would suggest a trial [of the urinary incontinence medication], starting off on a lower dose first and titrating up to the therapeutic dose if it [medication] is still not effective.”

– Pharmacist



Guiding principle

#7

Information about urinary incontinence medication should be provided in an appropriate format.

When starting a new medication to manage urinary incontinence, provide information about the medication to the person living with dementia and/or their substitute decision maker and caregivers, as appropriate. This information should include but is not limited to:

- purpose of medication
- how and when to take medication
- potential benefits
- potential side effects and how to manage them

This information should be communicated in a format that the person living with dementia and/or their substitute decision maker understands, ideally in both oral and written format.



“As a carer, I kind of really appreciate it when things are really clear and [written in] bullet points, very clear, plain English, so it’s just quick for me to digest. I felt like I’ve understood it and I feel like I’m informed. And therefore, more confident about what’s being prescribed, and what I should be looking out for.”

– Carer

“I think supporting them [person living with dementia] and... pointing out the adverse effects, because a lot of those anticholinergic [medication adverse] effects they’ll sometimes just accept as normal. They’ve got a dry mouth, and they haven’t realized that it’s because of the medication that they’re on. So, I think just setting out [adverse effects] clearly.”

– Pharmacist



Guiding principle

#8

Medication for urinary incontinence should be proactively monitored to ensure meaningful, person-centred benefits and ongoing need.

Monitor benefits of medication with the person living with dementia and/or their substitute decision maker to ensure that the medication is providing meaningful improvements in urinary incontinence symptoms that align with the person's goals of care. Urinary incontinence symptoms (e.g., number of urinary incontinence episodes per week, number of visits to the toilet each night) should be monitored and documented regularly to assist in evaluating the benefits of the medication and ongoing need for the medication.

Meaningful improvements will vary from individual to individual, and benefits should be discussed holistically (e.g. cost of medication may be prohibitive for some individuals, but for others cost of treatment may be offset by savings in other areas such as reduced reliance on continence products).



“I wanted so much for it [newly prescribed medication for urinary incontinence] to be better [more effective compared to previously trialled medication] that I think it was better. But honestly over time, I’m not sure it was any better.”

– Person living with dementia

“If you don’t give people measurable ways to assess if [the medication] is working, they’re [person living with dementia] like, I’m not sure. ... But if I say to them, ‘last night, how many times did you need to get up to go to the toilet?’, they’ll be like ‘I got up twice’ and I’ll be like ‘okay, that’s really good, when you first came in, you were getting up 6 times. So [the medication’s] made a big improvement.”

– Continence nurse



Guiding principle

#9

Medication for urinary incontinence should be proactively monitored for potential harms to guide ongoing use.

Monitor for potential side effects of the medication with the person living with dementia and/or their substitute decision maker. Proactive, person-centred monitoring for actual or potential medication-related harms can help to ensure timely recognition and management, and help to distinguish potential side effects from other causes (e.g., progression of dementia).

Document and consider any changes in health status potentially related to the medication (e.g. falls, confusion, dry mouth, constipation) when evaluating ongoing need for the medication.



“So, the side effects of those particular medications, they [prescribers] will write in their notes what to monitor for. So, we [nursing home staff] have a system where we can set tasks, so it prompts every shift to document in that way, if that resident had dry mouth and whatever symptoms they document that way.”

– Aged care nurse

“The first question we want to know when you’ve started a drug, any drug really, is can you tolerate it? And some people say that there are side effects, but [the] side effects are tolerable, so it’s okay. But if the side effects are intolerable, even if it’s causing good [benefits] then it’s often difficult to justify. So, you might have to try more than one drug.”

– Prescriber



Guiding principle

#10

Medication for urinary incontinence should be regularly reviewed and deprescribed as appropriate.

Regularly and collaboratively assess the ongoing need for medication with the person living with dementia and/or their substitute decision maker to ensure that treatment remains beneficial, safe and aligned with the goals of care.

Deprescribing (dose reduction or cessation) may be considered when:

- treatment goals are not achieved or are only partially achieved
- when it is unclear if the medication is providing a meaningful benefit
- when potential or actual harms of ongoing medication use outweigh benefits
- when there are changes in the person's goals of care (e.g., need to minimise polypharmacy, progression of dementia, transition to palliative care)



“I discuss [with the person living with dementia or substitute decision maker] that there are some medications that may worsen their cognition or their memory, and it may be worth trialling a reduction of the dose and seeing if that helps to improve the symptoms... So I give them the pros and cons of the choice and let them be involved in that decision-making process.”

– Pharmacist

“Working in a dementia population where things are often relentlessly progressing, often these medications are started at a time when patients care [about their urinary incontinence], and if they're used longer term, they're ceased at a time when patients no longer care about their incontinence so it no longer has the same impact.”

– Prescriber

For more information

or resources about dementia or urinary incontinence, please visit:

Dementia Australia

☎ 1800 100 500 🌐 www.dementia.org.au

Continence Health Australia

☎ 1800 33 00 66 🌐 www.continence.org.au

Guiding Principles Checklist

Before starting medication for urinary incontinence, I have:	✓
Considered the type of urinary incontinence and potential contributing factors.	
Discussed and documented individual treatment goals with the person receiving care.	
Trialled non-medication strategies.	
When starting medication for urinary incontinence, I have:	✓
Used shared decision making to choose a medication that aligns with the person's goals of care.	
Discussed and documented medication treatment expectations.	
Started medication at a low dose and planned the next review date.	
Provided information about the medication in an appropriate format for the person receiving care.	
When continuing medication for urinary incontinence, I have:	✓
Monitored medication to ensure meaningful, person-centred benefits and ongoing need.	
Monitored potential harms of medication to guide continued use.	
Reviewed medication to assess whether medication should be deprescribed.	

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Disclaimer: This document is a general guide for safe and appropriate use of medication as part of a holistic approach to the management of urinary incontinence. Any recommendations should be subject to healthcare professional judgement as well as the individual circumstances and the preferences and values of the person living with dementia.

