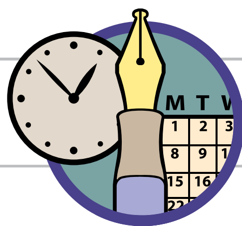

Leah Klusch

Focus On: Urinary Incontinence

Reducing risk and improving quality of care can be done simultaneously as providers face renewed scrutiny.

It is interesting to talk to health care professionals working in skilled nursing facilities about urinary incontinence. Many express frustrations over programs and plans with poor implementation, some look at the issue as a necessary evil with elder care, few can discuss the actual causes of the problem, and some still believe that it is a normal part of aging and should be tolerated with the use of absorbent products.

Under The Microscope

There needs to be a unified focus on the issues surrounding urinary incontinence, including proper assessments, medical consultation, treatment options, training, and education of the staff about the issue and treatment options for elders in the post-acute care setting. So where do providers begin to examine the issues, and what steps can the clinical and interdisciplinary team (IDT) take to resolve the barriers to quality care?

Quality care for elders in this area is so very important because of all the negative implications—both clinical and psychosocial—that can impact the outcome of the care delivery process if incontinence is not properly assessed and treated.

The past five years have produced significant, clear clinical information about the topic, along with focus from nursing and medical professionals dedicating their practice to its identification and treatment.

WHAT TO EXPECT FROM SURVEYORS

The revised Quality Indicators/Quality Measures (QI/QM) from the MDS 3.0 data set have not been finalized at this time, but it is evident that the statistics will measure the number of residents with indwelling catheters and the number of residents who have an increase in the level of incontinence from assessment to assessment.

The accuracy of the assessment process during the assessment reference period is now more important than ever. Coding of the level of continence in section H of the data set must be accurate and monitored by the team to prepare for regulatory focus once the QI/QM database is finalized and the reports are utilized by the surveyors.

Proactive data tracking in this area is very important now to identify if declines are being recorded. Look at the data now, and identify residents needing toileting programs and specific interventions as part of the facility's quality assurance program before issues become part of the survey process.

MDS 3.0 Changes Are Key

The focus from the regulatory side of the industry on the treatment for urinary incontinence, as well as the change in the data required by the Centers for Medicare & Medicaid Services (CMS) related to the topic on the minimum data set (MDS) 3.0 and the Care Area Assessment process that precedes care planning, have created more interest and discussion.

Survey agencies in all states are responding to the risk issues related to incontinence, such as skin rashes or breakdown, falls, social isolation, and psychological well-being and social interactions within the structure of the F-tag 315 requirements.

Facilities must be sensitive to the issues related to the problem and review the data related to all residents who have CMS-defined incontinence. It is also important to review programs and services utilized with the knowledge that regulatory scrutiny in this area has been steadily increasing.

There are solutions for residents and for the team that is providing care. There are two important issues to consider. First, what knowledge do the clinical team and caregivers possess concerning the causes and factors that impact continence? Second, how do caregivers assess, plan, and treat elders with urinary incontinence to promote independence and well-being? The topic is being discussed throughout the care delivery process.

The change in the assessment data from the MDS 2.0 to the MDS 3.0 should lead the care team to discuss the definitions, assessment process, and treatment options that need to be coded, as well as the revised definitions

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of the levels of incontinence that need to be reported on the data set.

Review, Review, Review

Every elder in the facility has assessments, and this issue will be coded according to the definitions in CMS' "Long-Term Care Facility Resident Assessment Instrument [RAI] User's Manual, Version 3.0," Chapter 3, Section H. The entire team should review the definitions in the RAI manual that are required to be used at this time.

Afterwards, have the team answer the following questions: What do the data say now? Who is coded at the various levels of urinary incontinence, and how are their plans set up to address the risk factors and improve their independence and well-being?

Remember, the MDS is a reflection of a slice of time during a resident's stay that is substantiated by data and information in the resident medical record. With this in mind, it is imperative that caregivers be certain that the clinical record accurately documents the assessment of continence and the type of incontinence a resident has.

Leadership is also important. The clinical team must be led by individuals who understand the clinical and psychosocial issues connected with the problem. Providers are strongly advised to consult a newly published resource on urinary incontinence, titled, "Managing and Treating Urinary Incontinence," a second edition by Diane Kaschak Newman and Alan J. Wein, 2009. It is a comprehensive clinical review of the problem, as well as a comprehensive discussion of assessment techniques, treatment options, and staff education strategies.

Barriers To Understanding Incontinence

Although many clinical professionals know very little about incontinence, its physiology, treatment options, and the negative impact it has on elders, it is not entirely their fault. Little time is spent on the topic in professional preparation programs, and few exceptional resources have been available to bring the treatment options to the industry in general.

However, the problem impacts the greatest majority of all the elders cared for in long term and post-acute care settings. In her book's preface, Kaschak Newman says, "The lack of knowledge on the part of clinicians about the causes and management options, and their assumption that urinary incontinence and overactive bladder are not true medical issues, hinder the detection and treatment of these insidious conditions."

Frontline staff feel the pain and discomfort of the resident when they are incontinent, but they frequently do not have the opportunity to discuss the issue and bring their practical ideas or feelings about the situation to the clinical team. This needs to change. And with accurate assessments at the time of the completion of the MDS and increased information about the issues and causes of urinary incontinence, clinical professionals can change it.

Simply put, all caregivers must increase their knowledge at this time. It can begin with the information in the RAI manual about coding Section H of the MDS, Chapter 4 information pages 4-25 and 26 about the Urinary Incontinence and Indwelling Catheter Care Area Assessment, and then in Appendix C of the RAI manual, the Care Area Resource Guide, pages C-25 to 28.

This is the basic structure of the assessment, definitions, basic information about the issue as a care delivery problem, and the related indicators and other issues that could impact the problem.

The clinical staff and the medical staff need additional information related to the issue, and that can come from clinical practice guidelines, resources as quoted above, or from professional associations, such as the American Medical Directors Association and others.

Incontinence needs to be addressed on assessment and during planning, along with proper diagnostics, when indicated. Interventions must be individualized and specific so the care delivery staff are consistent with their interventions.

A thorough discussion of the anatomy and physiology of

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PLANNING FOR CARE

The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are:

1. Determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;

2. Completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and

3. Implementing appropriate, individualized interventions and modifying them as appropriate.

Source: CMS' "Long-Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0," Chapter 3, Section H, page 3

the lower urinary tract with learning materials must be provided for the lead clinical managers as well as a review of the interventions and programs that can reverse or impact the frequency of incontinent episodes.

New Programs Can Help

Intervention approaches are changing constantly, and many high-impact treatments and programs, are now proven and accessible in many areas. Urology programs throughout the country are researching and developing interventions with success. Mobile urology diagnostics are now available in a few areas of the country and have been met with great enthusiasm and success.

Retraining and scheduled toileting programs are being offered with exercise programs, combining nursing and therapy disciplines. Restorative programs that include toileting programs with specific goals and interventions need to be developed along with strong clinical support and therapy input when necessary.

All toileting programs need to be reviewed for efficacy and specifics for individualization in the plan, as well as MDS coding since the October 2010 3.0 transition. The coding on the MDS 3.0 has new definitions for urinary continence that include the outcome of toileting programs by counting episodes of continent voiding or episodes of incontinence during the look-back period, as well as the coding of the current toileting programs in item H0200-C.

Review what the current MDS 3.0 database contains, and then review from there to check for accuracy. The guidance and definitions in the RAI manual, Chapter 3, Section H, must be discussed by the clinical and care planning team.

Pay particular attention to the Planning for Care section on page H-3. This contains the regulatory references and a significant guidance on how to handle many issues. It lists three steps to ensure that the elder receives appropriate treatment to restore as much bladder function as possible (*see box, left*).

What Regulators Will Look At

Regulators will have this direction as a reference when they review the services and outcomes related to incontinence and toileting programs.

Examples of the comments in this section include a reference to programs that decrease incontinence, not necessarily eliminate it; consideration of reversible or treatable causes or issues; referral to practitioners specializing in diagnosis and treatment of bladder function and the programs needed for elders who do not respond to programs to maintain dignity; quality of care; and good skin care.

The IDT should use this section of the RAI manual as a guide for discussions, as well as the Care Area Resource guidance on all comprehensive assessments.

The clinical team should do a complete evaluation of the types of incontinence products being used by the facility, as well as the sizing options for the elders using products. A wide variety of product types and proper sizing are necessary to meet the needs of elders, and some toileting programs can

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Facilities need to evaluate the quality of the data in the 3.0 database now and see that the proper definitions have been used to identify the elder's level of incontinence.

utilize a mixture of retraining or scheduled programs and some product use as well.

The RAI manual also has the Steps for Assessment of the Current Toileting Program or Trial, item H0200C in Chapter 3, page H-5. This manual instruction lists three requirements that need to be documented in the record for the toileting program to be included in the coding for this item. Care plan teams and clinical managers need to be certain that all the requirements are met before they identify the toileting program in the plan or on the MDS 3.0 in this section.

On page H-6 of the RAI manual there is a list of programs that are not to be included in the coding for this section. This is important information for the MDS nurse and the clinical leadership on the unit.

The definition of continence and urinary incontinence are in the RAI manual on page H-7, as well as specific guidance to plan and implement appropriate programs for all elders with urinary incontinence whether they respond to a toileting program or not.

Put The Guidance To Use

The IDT and the clinical leadership of the facility must look at all the issues related to urinary incontinence and appreciate that the information from CMS in F-tag 315 and the updated MDS 3.0 manual for section H of the data set have a lot of specific guidance, definitions, and criteria that need to be used in the frontline documentation and the formulation of the toileting program.

Facilities need to evaluate the quality of the data in the 3.0 database now and see that the proper definitions have been used to identify the elder's level of urinary incontinence and the programs that are being implemented. CMS has given a lot of guidance about the issue and the qualifications for a toileting program to be listed. This needs to be addressed in the records and nursing documentation.

This is a complicated issue and must be addressed by the IDT and the clinical team with specific focus on policy, CMS guidance through the F-tag 315, and the information in the RAI manual for coding section H of the MDS 3.0 data set. Clinical professionals need to have excellent current references related to urinary incontinence and be able to access diagnostics, as well as current treatment for the elders.

Check Out New Protocols

Many new interventions are available now that were not tested or proven five years ago, so clinical leaders and medical directors need to identify availability in their area and begin to use high-quality consults and diagnostics that would identify the cause of the incontinence, as well as the proper interventions.

The care plan should be individualized for the toileting programs, and outcome tracking is essential. If the elder does not respond to the toileting program or the cause is irreversible, then an individualized program of incontinence product sizing and product use should be implemented.

The entire team, including the elder, need to assess, investigate options, properly document, and plan care that is focused on improving the continence status of the elder through programs and clinical interventions. The goal should be to interfere with as much incontinence as possible or manage the care so other risks stay low and the quality of life for the elder is as positive as possible. ■

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