



Oklahoma State
Department of Health

Volume 1, Issue 3

July 2015

Special points of interest:

- Director’s Corner: Governor’s Healthy Aging Summit
- OASIS Coding Tips
- Automation Tips, Reminders & Updates

Interventions in Incontinence

-Wanda Roberts, RN

According to the AHRQ incontinence affects at least 17 million Americans and is the second leading cause of institutionalization in elderly adults. Incontinence impacts an individual in multiple ways. It can increase the likelihood of infection, skin breakdown and injury. Multiple studies show a correlation between falls, hip fractures, and incontinence (see [http://www.aggjournal.com/article/S0167-4943\(06](http://www.aggjournal.com/article/S0167-4943(06)

[00003-3/references](http://www.aggjournal.com/article/S0167-4943(06)). Additionally, social functioning, psychological well-being, and quality of life are affected by incontinence.

In effort to treat incontinence it is important to first recognize the different types of incontinence. Stress Incontinence is an involuntary loss of urine with a sudden increase in intra-abdominal pressure (e.g. coughing, sneezing, and exercise). Urge incontinence or overactive

bladder is an involuntary loss of urine with urgency. It is usually associated with frequent urination during the day and night. In overflow incontinence the bladder is full at all times and leaks at any time, day or night. Usual symptoms are a slow stream and difficulty urinating. This type is more common in men as a result of prostate problems. Functional incontinence is related to functional limitations in the patient (continued on page 2)

NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
Nancy Atkinson, Service Director

OASIS

Director’s Corner: Diane Henry, RN

Immobility and dementia are the most critical factors contributing to the development of urinary incontinence in elderly individuals.⁴ Immobility increases the likelihood of incontinence in the elderly by preventing them from getting to the toilet independently. If immobility and urinary incontinence are left untreated the individual may experience an increase in negative outcomes, including falls.

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of both fatal and nonfatal injuries among older adults. Even if they are not injured, many individuals who ex-

perience a fall develop a fear of falling. This fear may lead to decreased activities and immobility, which leads to poor outcomes in numerous areas such as incontinence and pressure ulcers.

The Oklahoma initiative from Governor Fallin, *Living Longer Better* is a Call to Action to accept the challenge to work together to improve the quality of health and life for Oklahoma’s older adults who deserve to be living longer better.

One critical piece of the initiative includes reducing falls in older adults in the community and long term care facilities. As we have learned, immobility and falls contribute to poor out-

comes and can even cause premature death.

To become a strategic partner in this important initiative go to: http://www.ok.gov/health/Protective_Health/Qualiy_Improvement_and_Evaluation_Service/Living_Longer_Better and access the Pledge form on the left side of the page. You can also click “Link me to a Partner” to find others working on the same topic you chose.

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such as decreased physical mobility, or decreased cognitive capabilities.

In addition to determining the type of incontinence it will also be essential to assess incontinence risk factors. These may include past surgical history, history of stroke, childbirth, urinary tract infections, and obesity to name a few. Also consider if the resident has high caffeine intake. Caffeine is a bladder irritant and may cause urgency. Poor fluid intake can have a counter intuitive effect of causing more frequent trips to the bathroom. Multiple medications have an effect on bowel and bladder, so all patients with incontinence or constipation should have their medications evaluated. Decreased mobility and environmental factors certainly should be considered. An environmental adjustment or mobility assistance may prove to be a rather simple solution to the problem.

A voiding diary is a useful and necessary tool in assessing the type of urinary incontinence. The diary should include and record the frequency of incontinence episodes, potential precipitating factors, and the resident's usual voiding patterns. The voiding diary can also include fluid intake as well as any medications that may have an impact. An on-going diary can be very useful in measuring the response to treatment. Thorough information collection is vital for developing an effective treatment program and care plan. An article from the *Annals*

of Long-term Care titled, "Practical Management of Urinary Incontinence in the Long-Term Care Setting" states the following: "Functional status, cognitive abilities, comorbidities, and preferences should be considered when developing a continence management plan. ...These care plans need to include an initial comprehen-

Cognitive Requirements for Continence

- aware of urge to void
- able to get to the bathroom
- able to suppress the urge until patient reaches the bathroom
- able to void when resident gets to the bathroom

sive assessment, measurable objective outcomes, time frames to assess whether the objective outcomes have been met, and the ability to modify the care plan if required. An appropriate outcome measure would be a decrease in the number of incontinent episodes, ideally determined objectively through the use of bladder diaries."¹

There are several behavioral strategies that may be effectively applied to reduce incontinence. These methods may be utilized both in patients with diminished mobility and dementia with successful results. Some of these methods include prompted voiding, habit training, and timed voiding.

Prompted voiding begins with the caregiver asking the dependent patient with inconti-

nence whether they need assistance with toileting. If the patient requests assistance and voids, the patient then receives positive feedback. The patient also receives positive feedback he/she is dry and does not need to void. Research shows prompted voiding does not have a benefit at night.²

Habit training involves identifying a patient's toileting pattern and using that to develop a toileting routine that aims to lengthen the voiding interval gradually but without incontinence. Timed voiding is assisted voiding initiated by a caregiver at fixed intervals. This is beneficial in patients who cannot toilet themselves.

Teach the client to respond to the urge to void as soon as possible in order to avoid voluntary urinary retention. Also teach him/her to try to empty the bladder completely at each voiding. You may also want to emphasize the importance of drinking plenty of water during the day but to avoid consuming liquids in the evening. Teach female clients about Kegel exercises to strengthen perineal muscles. Explain the signs and symptoms of UTI including pain or burning on urination, changes in urine color or clarity, malodorous urine, or changes in voiding patterns (e.g., nocturia, frequency, dribbling).³

1. Holroyd-Leduc, J, Lyder, C, Tannenbaum, C. Practical Management of Urinary Incontinence in the Long-Term Care Setting. *Annals of Long-Term Care* 2006; 14(2): 30-37

2. Ouslander JG, Ai-Samarrai N, Schnelle JF. Prompted voiding for nighttime incontinence in nursing homes: Is it effective? *J Am Geriatr Soc* 2001; 49(6):706-709.

3. Ouslander JG, Schnelle JF, Uman G, Fingold S, Nigam JG, Tuico E, & Bates-Jensen B. Predictors of successful prompted voiding among incontinent nursing home residents. *Journal of the American Medical Association*, 1995b; 273(17):1366-1370.

4. Leung, Felix, Schnelle, John Urinary and Fecal Incont in NH Residents. *National Institutes of Health, PMC2614622.*



The International Continence Society Defines incontinence as: a condition where involuntary loss of urine is a social or hygienic problem (ICS, 1987)

Urinary Incontinence M1610

The clinician must complete a thorough assessment to determine if the patient is incontinent of urine and score M1610 and M1615 accurately. Sometimes the patient may not want to admit they are incontinent so be alert for an odor of urine when you assess their bathroom at SOC. If the patient is receiving aide services, then ask for input from the aide at follow-up assessments.

M1610 will be scored as “1—Patient is incontinent” if the patient is incontinent at any time. The patient may state “only when I sneeze or laugh”, “sometimes I leak a little bit”, etc. Any of these statements would indicate the patient is incontinent and would be scored as such.

The next step is to determine when the urinary incontinence occurs and score at M1615. Score 0—Timed-voiding defers incontinence, if the patient can self-schedule toileting or the caregiver can prompt or assist the patient to the toilet. If timed voiding does not defer incontinence do not select Response 0.

Timed voiding determines the patient’s pattern for voiding and schedules toileting to prevent episodes of leaking. Timed voiding is a compensatory strategy and does not cure incontinence.

If the patient is unable to prevent escape of even small amounts of urine when coughing, sneezing, or laughing,

then Response “1—Occasional stress incontinence” would be the appropriate score.

If incontinence happens regularly, determine when the incontinence usually occurs and select responses 2, 3, or 4 depending on if the incontinence occurs during the night only, during the day only or during the day and night.

Facilitating Urinary Elimination Self-Care¹

- Teach the patient and family to maintain easy access to the bathroom. This includes removing rugs and ensuring halls and doorways are free of clutter.
- Suggest graduated lighting for nighttime voiding or dimly light hallways and rooms.
- Advise the patient and family to install grab bars and elevated toilet seats as needed.
- Obtain orders for physical therapy to provide training on safe transfers and ambulation.
- Physical therapists who have been trained may also help with pelvic floor muscle training, electrical stimulation with surface electrodes, magnetic stimulation and electrical stimulation of the posterior tibia nerve.
- Suggest clothing that is easy to remove, such as elastic waist pants or Vel-

cro closures.

M1610 Q&A: A patient is determined to be incontinent of urine at SOC. After implementing clinical interventions (e.g., Kegel exercises, biofeedback, and medication therapy) the episodes of incontinence stop. At the time of discharge, the patient has not experienced incontinence since the establishment of the incontinence program. At discharge, can the patient be considered continent of urine for scoring of M1610, to reflect improvement in status?

Answer: Assuming that there has been ongoing assessment of the patient’s response to the toileting program, this patient would be assessed as continent of urine and scored as “0—No incontinence or catheter at M1610.

Timed voiding was not specifically mentioned as an intervention utilized to defer incontinence. However, if at discharge, the patient was dependent on a timed-voiding program to defer incontinence, the appropriate response for M1610 would be 1—patient is incontinent, followed by response 0— to M1615, timed-voiding defers incontinence.

1. [Wps.prenhall.com/wps/media/objects/745/763096/urinary_elimination.pdf](http://wps.prenhall.com/wps/media/objects/745/763096/urinary_elimination.pdf); Teaching: Home Care Urinary Elimination
2. AHRQ Guideline Summary NGC-10135; Conservative Treatment In: Guidelines on Urinary Incontinence.



OASIS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation

Recent CMS Q&A

QUESTION 2: When we learn that a patient is home from a qualifying stay, but we have not received orders to resume care, do we still see the patient within the 48-hour timeframe? Or should we wait to complete the ROC assessment until after we have resume orders, even if it causes the assessment to be late?

ANSWER 2: Physician orders are required to provide care. The resumption of care comprehensive assessment must be completed by a qualified clinician (RN, PT, OT, SLP) within two (2) days of the patient's return home from the inpatient facility or within two (2) days of the agency's knowledge of the patient's return home.

In the circumstance where an agency does not have orders within the two days from inpatient facility discharge or agency knowledge of discharge for a recently discharged patient, the agency should document the details of the efforts to obtain orders, and complete the ROC visit and assessment as soon as orders are received. The time frame to complete the ROC assessment does not vary based on the date the agency obtains the physician orders to provide care, so note that the ROC assessment that is completed greater than two days after inpatient facility discharge or agency's knowledge of the patient's return home would demonstrate noncompliance with the ROC timeframe (Reference January, 2015 CMS Q&A's).

Current & Upcoming Information

-Windows Vista/TLS Settings

Version 1.2 of TLS setting is not available/supported by the latest version of IE on Windows Vista computers. Due to that limitation, Windows Vista users will not be able to access QIES applications after the TLS 1.2 setting is put in place on the QIES server side. CMS asked states to please pass this information along to any providers or contractors through their standard means of communication with these groups.

-Reminder, the rollout plan for the ICD 10 is still "scheduled" for October 1, 2015. Make sure you and your software will be as prepared as possible when this goes into effect.

-The ICD-10 changes are **not** retroactive. Assessments with M0090 dates **prior to** October 1, 2015 should continue to contain ICD-9 items and conform to the current v2.11.3 specifications. Assessments with M0090 dates **on or after** October 1, 2015 should conform to the new v2.12.0 specifications.

--OASIS 0003D and 0004D package reports that relate to prior deficiencies, complaints, previous surveys is now located under the provider reports category within CASPER.

[Oklahoma State Department of Health](#)

[QIES Help Desk](#)

1000 N. E. 10th Street
Oklahoma City, OK
73117-1299

Phone: (405) 271-5278
Fax: (405) 271-1402



MARK YOUR CALENDAR!

Upcoming OASIS Training (Tentative)

OASIS Automation

August 12, 2015

Shawnee

OASIS Clinical Training

November 17, 2015
OKC

November 19, 2015
Tulsa



Website:
<http://oasis.health.ok.gov>

Automation Tip: Remember to occasionally pull CASPER reports in order to compare to software generated reports. CASPER reports are housed with CMS and are utilized for the survey process. What appears on the CASPER reports is a result of OASIS submitted and accepted records in the Federal Database and could be different than what appears on your software generated reports.