



Oklahoma State  
Department of Health

NEWS YOU CAN USE

MDS

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

**Special points of interest:**

- Director's Corner:
- MDS Q and A
- Automation Tips, Reminders & Updates

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# 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.aggiournal.com/article/S0167-4943\(06](http://www.aggiournal.com/article/S0167-4943(06)

[00003-3/references](http://www.aggiournal.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 involun-

tary 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 resident such as (continued on page 2)

## Director's Corner: Diane Henry, RN

Immobility and dementia are the most critical factors contributing to the development of urinary incontinence in nursing home residents.<sup>4</sup> Immobility increases the likelihood of incontinence in residents by preventing them from getting to the toilet independently. If immobility and urinary incontinence are left untreated the resident 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 outcomes and can even cause premature death.

To become a strategic partner in this important initiative go to: [http://www.ok.gov/health/Protective\\_Health/Quality\\_Improvement\\_and\\_Evaluation\\_Service/Living\\_Longer\\_Better](http://www.ok.gov/health/Protective_Health/Quality_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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## Interventions in Incontinence (continued from page 1)

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 are just a few. Also consider if the resident has a 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 residents with incontinence or constipation should have their medications evaluated. Decreased mobility and environmental factors certainly should be considered. An environmental alteration or assistance with mobility 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 ongoing 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,

### Cognitive Requirements for Continence

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

ties, and preferences should be considered when developing a continence management plan for each long-term care resident. The resident or his/her legal representative should be involved in the design of an appropriate care plan. The CMS guidance allows long-term care facilities to develop standard treatment protocols or care plans that can then be appropriately adapted to the individual. These care plans need to include an initial comprehensive 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."<sup>1</sup>

There are several behavioral

strategies that may be effectively applied to reduce incontinence. These methods may be utilized both in residents 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 resident with incontinence whether they need assistance with toileting. If the resident requests assistance and voids, the resident then receives positive feedback. The resident 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.<sup>2</sup> Habit training involves identifying a resident'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 residents who cannot toilet themselves.

Research findings show that a resident's appropriate rate of toileting during the first three days of the intervention is a good predictor of long term toileting success.<sup>3</sup>

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)

## Interventions in Incontinence (continued from page 2)

### Algorithm for the cognitively impaired and immobile resident.<sup>1</sup>

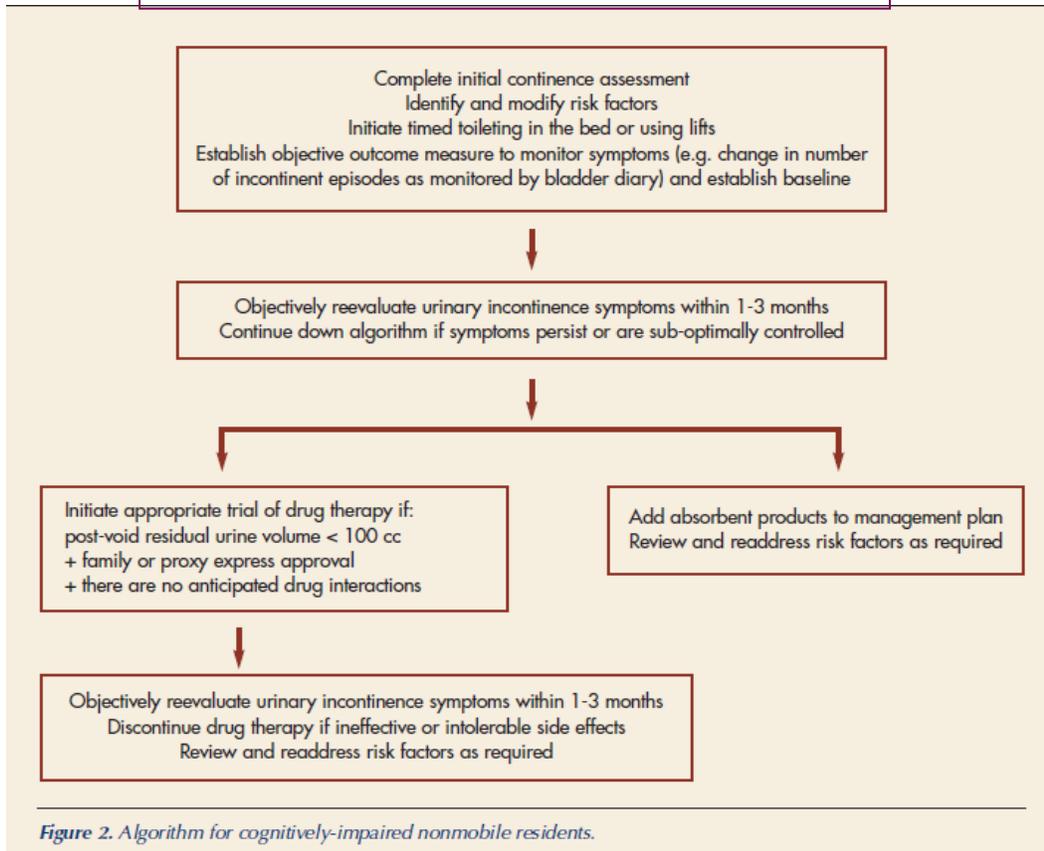


Figure 2. Algorithm for cognitively-impaired nonmobile residents.

**“Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being...”**  
(Code of Federal Regulation, 42 CFR 483.25)

## MDS Coding Tips H0200C

Regulations require that resident who is incontinent receives appropriate treatment and services to prevent urinary tract infections and to restore as much bladder function as possible (SOM and RAI Manual).

One step to ensure residents are receiving appropriate services is develop an individualized, resident-centered toileting program. Many residents (including those with dementia) respond to a toileting program, especially during the day. Research has shown that one

quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.

The resident’s care plan must show that the resident’s toileting program is:

- ◆ Organized
- ◆ Planned
- ◆ Documented
- ◆ Monitored and
- ◆ Evaluated

Assess the resident’s bowel/bladder pattern to determine appropriate times to toilet the

resident.

For residents who are on a current toileting program in the 7-day look-back period, the assessor would code 1, yes for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder training, prompted voiding, habit training/scheduled voiding). If the resident prefers not to be awakened at night to toilet, code “yes” if the resident is on a toileting program during the day.

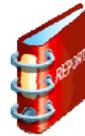


# MDS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation

## MDS Manual Updates

I routinely receive calls where facilities are utilizing outdated RAI (MDS) Manuals and rules. Therefore, I wanted to make sure you are aware of the new errata document dated February 5, 2015, which gives additional clarification and examples to the RAI manual, as it relates to A1600 through A1900. To download the Errata document go to: [QTSO.com](http://QTSO.com), click MDS 3.0, scroll down to the bottom of the page and locate MDS 3.0 RAI Manual v1.12R Errata, then print or save as desired. This Errata document includes information about the changes along with the new RAI manual pages. We will be training on this information during our 3-day Clinical Workshop December, 9-11, 2015, as well. A word of caution however, you may want to retain your old manual for historical rules that may be required at a later date. I also recommend that you watch for any issues that may arise due to the ICD-10 implementation scheduled for October 1, 2015. Some early, non-finalized, release data can also be located at [QTSO.com](http://QTSO.com) by clicking MDS 3.0 Technical Information, rather than the RAI manual, and then scroll to the bottom. Some early release information for October 1, 2015 related to Item subsets and specifications is available for download and preview as stated above. Are you prepared? Take a peek!



## MARK YOUR CALENDAR!

Upcoming MDS Training (Tentative)

### Automation

October 14, 2015  
Shawnee

### 3 Day Clinical Training

December 9-11, 2015  
Shawnee

## 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 are prepared as possible when this goes into effect.

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

-Be aware, CMS has rolled off assessments from the MDS Missing OBRA Assessment Report that are greater than 36 months old. Saying this, your report should look much cleaner.

## Contact Us!

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**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 QM's and survey process. What appears on the CASPER reports is a result of MDS submitted and accepted records that can be different than what appears on your software generated reports.