Low-Risk Residents Who Lose Control of Bladder or Bowel

Why is this important?

- Prevalence is growing in long-term care (LTC). Between 50 and 70% of nursing home residents have urinary incontinence (UI).
- UI increases the risk of falls by as much as 26% and bone fracture by as much as 34%. Most hip fractures can be traced to nocturia, especially if the resident has urgency-type incontinence.
- More than 1 in 5 female residents become incontinent within one year of admission to a nursing home.
- UI impacts a resident's quality of life. Residents with UI tend to avoid social activity and interaction, lose self esteem and are increasingly dependent on caregivers for activities of daily living (ADLs).

This Minimum Data Set (MDS) 3.0 Measure is a Long-Stay Quality Measure and reports the percentage of long-stay residents who frequently lose control of their bowel or bladder during the seven-day look-back period preceding the MDS 3.0 target assessment date.

MDS Target Assessment Used:

- Most recent three months of long-stay period (>101 days in facility episode)
- Reason for assessment: Admission, quarterly, annual or significant change in status

Numerator:

A resident will trigger this measure if, on his or her most recent MDS 3.0 Target Assessment, the following question for Urinary Continence or Bowel Continence is answered during the seven-day look-back period:

- Frequently incontinent (7 or more episodes of urinary incontinence but at least one episode of continent voiding OR 2 or more episodes of bowel incontinence but at least one continent bowel movement)

OR

- Always incontinent (no episodes of continent voiding or continent bowel movements)

Denominator:

All long-stay residents with a selected target assessment, except those with exclusions. (If a resident does not have a high-risk condition, he or she is included in the denominator as a low-risk resident.)

Exclusions:

- The target assessment is an admission, a PPS five-day assessment or a PPS readmission/return assessment
- Resident is not included in the numerator and MDS answers on bladder and bowel continency are blank
- Any resident who has any of the high-risk conditions on the target assessment:
  - ○ Severely impaired cognitive skills for daily decision making ○ Short-term memory problems ○ Summary BIMS score of ≤ 7 ○ Totally dependent in self-performance in bed mobility ○ Totally dependent in self-performance in transferring ○ Totally dependent in self-performance in locomotion on living unit ○ Comatose ○ Indwelling catheter ○ Ostomy ○ Not previously excluded as high risk but MDS data is missing for any of the above high-risk conditions

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Incontinence Types Information and Some Tips and Suggestions:

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Urge	• Most common cause of UI in elderly • Resident can feel need to void but is unable to inhibit voiding long enough to reach and sit on commode • Common to wake to pass urine at night Consider: Pelvic floor muscle rehabilitation or prompted voiding Medications: Anticholinergics, imipramine
Stress	• Most common type of UI in older women • Lost of small amount of urine with physical activity such as coughing, sneezing, laughing, etc. Consider: Pelvic floor muscle rehabilitation Medications: Imipramine, dulozetine Also: Anti-incontinence rings may help, but can be difficult to fit
Mixed	• Common in many elderly, especially women • Combination of Urge and Stress incontinence; involuntary leakage associated with urgency and exertion (bladder spasms and stress incontinence) • One type of symptom (e.g., urge, stress) often predominant Consider: Prompted voiding
Overflow	• Occurs when bladder is distended from urine retention • Weak stream, hesitancy, incomplete voiding, frequent voiding, constant dribbling • Can be due to outlet obstruction, hypotonic bladder or both • Increased post-void residual (PVR)
Functional	• Secondary to other factors such as physical weakness, poor mobility, poor dexterity, cognition, environment, diminished vision, aphasia or psychological
Transient	• Related to delirium, infection, atrophic urethritis or vaginitis, medications, increased urine production, restricted mobility or fecal impaction

Treatment and Interventions:

Behavioral Treatment

- Mainstay of treatment
- Least invasive with no complications
- Modify resident behavior and/or environment (e.g., pelvic muscle rehabilitation, reduce/control urgency, bladder/bowel training to reduce frequency, fluid management)

Critical success factors:

- Education of caregiver
- Education of resident
- Availability of staff
- Consistent implementation of interventions

Bladder Rehabilitation/Retraining

- Requires resident to resist or inhibit sensation or urgency, to postpone or delay voiding and to urinate according to timetable vs. urge to void
- Intervals between voiding may be progressively increased
- Usually takes minimum of several weeks

Appropriate resident:

- Fairly independent with ADLs
- Occasional incontinence
- Aware of need to void
- Has goal to maintain his or her highest level of continence

Pelvic Floor Rehabilitation

- Strengthens voluntary peri-urethral and per-vaginal muscles that contribute to closing force of urethra and support of pelvic organs
- Kegel exercises to strengthen muscles

Appropriate resident:

- Cognitively intact
- Able and willing to participate
- Has Urge and/or Stress incontinence

Prompted Voiding

- Teaches resident to recognize bladder fullness or need to void, ask for help or respond when prompted to toilet
- Three components:
  1. Regular monitoring with encouragement to report incontinence status
  2. Using schedule and prompting resident to toilet
  3. Provide positive feedback when resident is continent and attempts to toilet

Appropriate resident:

- Can be used with dependent or more cognitively impaired residents who have Urge or Mixed incontinence

Habit Training/Scheduled Voiding

- Scheduled toileting at regular intervals on planned basis to match resident's voiding habits
- Habit training: Timed voiding based on resident's usual voiding patterns
- Scheduled voiding: Timed voiding, usually every three to four hours while awake

Appropriate resident:

- Cannot self-toilet

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Common Pitfalls

- Inaccurate or incomplete documentation in three-day diary
- Program is not individualized according to resident's comprehensive assessment
- Staff do not follow program as identified for resident

Tips for Success

- Ensure nurse manager oversees three-day diary each day, every shift
- Review/audit assessments to determine if diary and assessments are consistent with resident's care plan and delivery of care
- Monthly summary by licensed nurse to check documentation and bring issues to care planning meeting(s)
- Include resident/family in process to help identify goals, patterns, barriers and solutions

Quality Assurance and Performance Improvement (QAPI) Features

(and how they apply to this measure)

1. Use data to not only identify your quality issues, but also to identify other opportunities for improvement—and then set priorities for action.
2. If your data indicates an issue or room for improvement, gather a multidisciplinary team to investigate. The team's focus should be on processes and systems, not people.
3. Performing a root cause analysis (RCA) to get to the heart of the problem. Using the Care Area Assessment (CAA) tool can be a useful framework for working through the RCA process on an individual resident.
4. Develop a feedback and monitoring system to sustain continuous improvement.
5. Build on residents' individual goals for health, quality of life and daily activities.

Steps for Improvement:

1. Run a Certification and Survey Provider Enhanced Report (CASPER) with resident-level data, so you can identify who is triggering this quality measure (QM).
2. Review Section H of the Minimum Data Set (MDS)/Resident Assessment Instrument (RAI) manual with your MDS coordinator so you can both understand the details about each resident who triggers. Review the Care Area Assessment (CAA) for Section H for more specific details about this trigger.
3. Audit ten residents' charts who trigger for this measure. Can you identify any trends or issues?
4. For those residents who trigger this measure:
   - Perform a thorough physical assessment for each resident upon admission, upon readmission, annually or upon new/onset of incontinence.
   - Review the ADL coding to ensure accuracy of mobility (i.e., make sure the resident does not meet exclusion criteria).
   - Review the need for restorative therapy.
   - Complete a three-day elimination patterns diary across all shifts and have the nurse manager audit it to oversee its completion.
5. Do a "deep dive" or root cause analysis to uncover potential causes and solutions to individual challenges for each of your residents with incontinence. Whenever possible, get feedback from the resident and/or his or her family. The goal is to meet the resident's needs—whatever that entails.