

Long-Term Care Survey Alert

Clip 'N' Save: Cover The Bases In Assessing Urinary Incontinence

If you're missing any of these pieces, watch out.

When the **Centers for Medicare & Medicaid Services** talks about a "comprehensive assessment" for incontinence, they mean business under the revised F315 survey guidance. The advanced draft of the final survey guidance at F315 suggests providers consider the following parameters:

1. **The resident's prior history of urinary incontinence**, including onset, duration and characteristics, precipitants of urinary incontinence, associated symptoms (e.g., dysuria, polyuria, hesitancy) and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI;
2. **Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream)** and, for those already experiencing urinary incontinence, voiding patterns over several days;
3. **Medication review, particularly those that might affect continence**, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedative/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention);
4. **Patterns of fluid intake**, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output;
5. **Use of urinary tract stimulants or irritants** (e.g., frequent caffeine intake);
6. **Pelvic and rectal examination** to identify physical features that may directly affect urinary incontinence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, distended bladder, or bladder spasms;
7. **Functional and cognitive capabilities that could enhance urinary continence** and limitations that could adversely affect continence, such as impaired cognitive function or dementia, impaired immobility, decreased manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, decreased vision, pain with movement;
8. **Type and frequency of physical assistance necessary** to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination;
9. **Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders** (e.g., Multiple Sclerosis, Parkinson's Disease or tumors that could affect the urinary tract or its function);
10. **Identification of and/or potential of developing complications such as skin irritation or breakdown;**
11. **Tests or studies indicated to identify the type(s) of urinary incontinence** (e.g., post-void residual(s) for residents who have, or are at risk of, urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs; and
12. **Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the**

toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, availability of urinals, use of bed rails or restraints, or fear of falling).