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Long-Term Care Survey Alert

Urinary Incontinence: Avert Costly Survey Citations

Take control of incontinence care using new quality measures.

A less-than-stellar approach to caring for incontinent residents will lead to costly survey citations, not to mention a long list of public relations and marketing woes. This summer, a new tool can help you improve your approach and do damage control, if necessary. The **Society for Post-Acute and Long-Term Care Medicine** (AMDA) recently had its full list of 21 urinary incontinence clinical practice guideline implementation measures accepted for inclusion in the **National Quality Measures Clearinghouse** (NQMC), an evidence-based repository affiliated with the **Agency for Healthcare Research and Quality.**

The new AMDA measures can be used to rate a facility's success in implementing the AMDA Urinary Incontinence in the Long-Term Care Setting Clinical Practice Guideline, but they can also be used to measure how a facility or individual is managing urinary incontinence in the nursing home setting.

Take A Closer Look

The measures are based on the four recommended components of the AMDA urinary incontinence management process: recognition, assessment, treatment, and monitoring. By adopting the full 21 measures, you can assess and improve your care in all critical areas, from the initial assessment to monitoring the ideal plan of care.

Start here: For many residents, the fight for improved continence starts at admission. Recognizing a problem early or the potential for incontinence could have a huge impact on the quality of care a resident will ultimately receive.

For example, every new admission should lead clinicians to review the incoming resident's transfer summary for a history of urinary incontinence, according to the new guidelines. To improve in this regard over time, the facility should track how often this is done. To see how your facility improves over time, first determine a baseline percentage when the guidelines are adopted. Then reassess the percentage at intervals of 3, 6, 9 and 12 months after guideline adoption.

Other admission-focused measures to track include the percentage of residents observed for current signs or symptoms of urinary incontinence on admission, percentage for whom onset and type of incontinence is identified (to the extent possible), and percentage diagnosed with urinary incontinence whose symptoms are documented by the practitioner in the patient's record.

Medication-related issues should be part of the discussion at admission, stresses **T.S. Dharmarajan, MD, MACP, AGSF**, clinical director of the division of geriatrics and director of the geriatric medicine fellowships at Montefiore Medical Center in New York City. "The patient's medications must be evaluated. Some can predispose to constipation and incontinence, and these should be identified and eliminated or replaced as appropriate. We also need to watch for medications with side effects that can worsen cognition and contribute to falls or other problems," he notes.

Train The Team

The best care always results from teamwork, affirms **Margaret Falconio-West, BSN, RN, APN/CNS, CWOCN, DAPWCA,** vice president of clinical education at Medline University. Involving family members when possible is the best-case scenario, leading to better outcomes for people with urinary incontinence and constipation. Buy-in from family members is also invaluable at survey time. Family members may be able to provide important background regarding a resident's medications, for example. An interview with family members upon admission might reveal that a certain medicine coincided with new cognitive difficulties or problems with balance problems that can exacerbate any tendency toward incontinence.

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Nurses are on the front lines but should definitely not be fighting the incontinence fight alone. Many players in the nursing home must be involved. Key players include nutritionists, nurses, pharmacists, and physicians.

Nursing Assistants Must Also Be Team Players

It's helpful for nursing assistants to understand how cognitive impairment affects continence care, so expectations about what residents can and cannot do on their own are realistic. Surveyors are trained to quiz nursing assistants on a variety of points related to incontinence care, such as whether they understand the interventions specific to each resident, such as bladder restorative programs. Nursing assistants are also expected to have been trained and know how to handle catheters, tubing, drainage bags, and other devices used during the provision of care and to know what, when, and to whom to report changes in status regarding changes in bladder and bowel function, such as frequency and character of urine, changes in hydration status, concentrated urine, and complaints of potential UTI symptoms such as change in odor, color, cloudiness.

Note: See sidebar on this page for more cautions about addressing significant changes.

Vital: Be sure to involve the pharmacist in reviewing a resident's history upon admission. Medication use can have an effect on continence. One medication-specific measure on the AMDA tool asks providers to consider the percentage of patients with urinary incontinence who have had non-essential anticholinergic medications discontinued to reduce the overall anticholinergic load. Another, under the Monitoring category, calls for tracking the percentage of patients who are being monitored for side effects of medications prescribed for the treatment of urinary incontinence.

Connect The Dots

Facilities considering adoption of the new quality measures should review survey guidance from the Centers for Medicare and Medicaid Services (CMS), to ensure optimum impact of guideline adoption.

Under the new tool's Assessment category, for example, AMDA urges that providers track the percentage of residents assessed for modifiable causes of urinary incontinence, so that interventions may be targeted to those factors.

Related survey hot spot: This potentially links to survey concern that a facility failed to identify a clinical rationale for the use of an indwelling catheter. Surveyors are trained to investigate the use of any and all catheters, so be sure the patient record reflects that priority. Acceptable rationales might be that urinary retention cannot be treated or corrected medically or surgically, or you might document that contamination of a Stage III or IV pressure ulcer on the sacrum has impeded healing.

You should also be sure that documentation reflects a thorough consideration of incontinence risk factors. The following should all be on your radar screen: impaired neurological, cognitive or physical functioning; inability to recognize the urge to void; behaviors such as resisting care that might interfere with continence; a diagnosis of depression, stroke, diabetes mellitus, Parkinsonism, UTIs, prolapsed uterus, prostatic hypertrophy, obesity, or urinary retention; use of a pessary; fecal impaction; and pain.

Domino effect: Shortcomings in continence care can put you at risk for other survey citations. Potential tags that are related to F315 (urinary incontinence) are: F157 notification of change, F241 dignity, F272 comprehensive assessments, F279 comprehensive care plans, F281 standards of practice/professional standards, F309 quality of care, F353 staffing, F385 physician supervision, F444 hand washing, F498 proficiency of nurse aids, and F501 medical director.

Resource: Ready to adopt the new clinical practice guideline measures? Go to www.amda.com/news/UI CPG Measurement Tool.pdf.

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