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MDS Alert

In the Spotlight: Catapult Your Continence Management Program To The Next Level

Follow this facility's decision-making tree to individualize care plans.

Win the war on urinary incontinence and watch the victors rise, including the residents' quality of life, the facility's fiscal health - and the staff's job satisfaction.

That's the key lesson that **Minnewaska Lutheran Home** in Starbuck, MN, has to share with other facilities looking to find ways to individualize residents' continence care plans. The facility's comprehensive approach to incontinence has paid off by improving residents' physical and psychosocial outcomes - and creating an odor-free environment that proves to be a powerful marketing tool in its own right.

The bottom line: Minnewaska has also slashed spending on incontinence products by 35 percent - from $26,000 to $17,000 - even though they use products that cost more on a per unit basis.

Not only that, "but by coding the MDS correctly and doing a comprehensive continence assessment, the facility can determine the exact level of care required for each patient - and the costs for such care," says the facility's DON **Karen Johnson, RN.** That way the facility can guarantee appropriate fee levels, she notes.

Consider these best-practice strategies from Minnewaska:

1. Perform a comprehensive admission assessment on all residents to determine their continence status and any risk for urinary tract infection. At Minnewaska, the assessment usually includes an ultrasound bladder scan, performed by CNAs trained in how to complete the noninvasive procedure.

Staff may do the scan even on a continent resident if the person has a history of urinary tract infection, according to Johnson. "Residents who have a significant residual (more than about 90 cc) after voiding are at risk for UTI," she adds. They also scan residents already in the facility who show a change in their urinary continence.

(The facility purchased the scanner equipment on its own and does not receive any special payment for doing the scans. "That was not our driving reason for performing the service," adds Johnson.)

Staff also uses the MDS to look for potential causes of incontinence. For example, they look at Section I (diagnoses), for items such as multiple sclerosis, stroke, UTI, Parkinson's and dementia, all of which can contribute to incontinence. (Other diagnoses impacting continence include diabetes insipidus, atrophic vaginitis, delirium, prostate problems, and kidney or bladder disease.)

The MDS staff also targets cognitive issues in Section B, communication problems in Section C, and medications in Section O (see the list of drugs known to cause or contribute to incontinence, Clip 'N Save: Does The Resident ...).

Section G (toileting and functional status) also plays into the continence equation. For example, by assessing the resident for Section G, staff identifies the type of clothing a person can manage most easily to toilet independently.

2. Identify the resident's specific incontinence problem to develop an appropriate plan of care. By using the bladder scan and MDS, the interdisciplinary staff figures out what's going on with a particular resident and individualizes the care plan.

For example, the ultrasound scan tells the nursing staff how much urine a person's bladder can hold before he has an incontinence episode. "If we see someone can hold 200 cc's to 300 cc's without telling us he has to go, then we know when to take him to the toilet before he has an overflow incontinence episode - or simply urinates because he doesn't recognize the need to void due to cognitive impairment," Johnson relates.

Another example: "If a resident has a lot of urinary urgency, staff teaches the person to hold a small amount of urine a little longer and stretch out the times between trips to the toilet," says Johnson. "Several residents are taking Ditropan for urge incontinence or overactive bladder," she adds.

The staff has also figured out how to determine what's going on with a resident who repeatedly says she has to go to the bathroom, but doesn't urinate when she sits on the commode.

"By scanning residents' bladders to see if they are empty when they ask to toilet, staff can tell if the person is having an anxiety problem - or perhaps a cognitive issue where they forgot they just went to the toilet," explains Johnson. "Or the person may want attention or have a behavioral pattern going on, so we assess that to figure out their underlying communication and needs."

The facility doesn't toilet everyone, but comes pretty close. "The state is quite surprised about the people we toilet successfully, including those with very low mini-mental scores," Johnson relates.

3. Incorporate absorbent products into the overall, individualized continence care plan. For example, one resident might wear a pad during the day and a pull-up brief at night - or just a pull-up at night because he can toilet during the day.

Another inside secret: The facility uses a "really good quality of brief," says Johnson. "Using a good product that doesn't leak and which the resident can manage easily pays off," she adds. The facility's "change rate" is one of the lowest in the nation. "At one point, our vendor thought we must be using another vendor's products, because our utilization of absorbent products is so low," says Johnson.

4. Use a simple system to monitor changes in each resident's continence to identify the cause and act quickly. The nursing staff is very attuned to residents who show any change in their continence status. "We put the resident's continence products at the bedside based on the person's usual usage," says Johnson. "So the charge nurse knows if the nursing assistants are asking for more product. If so, we figure out what's going on."

Use the MDS to Track Outcomes

Assess the resident's customary routines (Section AC) on admission to determine how a resident's incontinence may be impacting his lifestyle in the community or previous setting, advises **Steven Littlehale, MS, APRN, BC,** a consultant with **LTCQ Inc.** in Lexington, MA. Then evaluate how that changes as the person's continence improves.

Residents who regain control of their elimination may show improvements in not only Section H, but also in the following sections:

1. Section E. Residents who improve their continence may show fewer indicators of sad mood.
2. Section F (psychosocial wellbeing). "Residents have much better self confidence if they are continent or only wear a small ultra-absorbent pad, if needed," Johnson relays.
3. Section J (falls and accidents or dehydration). Falls can be caused by urine spills or the resident's effort to make it to the bathroom unassisted. Also, "urinary incontinence can cause dehydration if a resident who develops bladder incontinence restricts her fluid intake," cautions Littlehale. The resident may show improved fluid intake as her incontinence improves.
4. Section M (skin condition). Incontinence can contribute to the development of pressure ulcers or prevent their healing.

5. Section N (activity pursuit patterns). "If residents know they have the right product that will really manage their incontinence ... they feel comfortable to visit with their families - to go to that baseball game with their grandkids or to a big family dinner," says Johnson.