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MDS Alert

Quality of Care: 4 Ways to Keep UTIs Off The Survey Radar Screen

Target risks and don't be fooled by conditions that mimic infection.

Err on the side of over-diagnosing UTI and you treat patients unnecessarily and breed bacterial resistance. Miss a case of UTI and you can set a resident up for systemic infection and other negative outcomes. Ether way, surveyors will be all over your case.

These proactive strategies will go a long way toward keeping your facility on track in diagnosing and treating UTIs appropriately.

1. Look for common conditions that simulate UTI or set the resident up for developing one. For example, constipation can cause low-grade fever, abdominal pain and low-grade bladder inflammation, if it's severe enough, says **Chesley Richards, MD**, an infection control consultant to the **Centers for Disease Control & Prevention.**

Constipation can also cause urinary retention, which offers a breeding ground for bacteria that may cause infection, adds **Joan Redden, RN**, vice president of clinical risk management for **Skilled Healthcare LLC** in Foothill Ranch, CA. But to detect constipation, the facility must have accurate records of bowel movements, she emphasizes. "Without this baseline, it's extremely difficult to manage constipation."

Atrophic vaginitis can also cause the same symptoms as UTI, Redden notes. Not only that, but atrophic vaginitis places the resident at risk for bacteriuria and UTI, adds Richards. "Transvaginal hormonal therapy is good not only for atrophic vaginitis, but it has been shown to decrease bacteria in the urine."

Poor fluid intake can cause UTI. "The interdisciplinary staff should look at fluid intake for residents at risk of or who have a history of UTI--or a current UTI," says Redden. Ensuring adequate fluid intake also helps prevent constipation, she adds.

Tip: Check fluid intake coding in Section J1d (insufficient fluid; did not consume all/almost all liquids in last three days) for the resident's last couple of MDS assessments to detect a pattern of poor fluid intake.

Don't make this mistake: Nurses frequently report the urine has a foul odor although the patient has no localized signs of infection but does have a positive urine culture, says Richards. What the resident really needs is to be rehydrated, he adds. "Then the nursing staff should re-examine the urine."

2. Look at Section I for diagnoses that can cause chronic urinary retention. These include multiple sclerosis, myasthenia gravis or post-stroke, suggests Richards.

Nursing homes can use a portable bedside ultrasound to check for urinary retention. "Bladder scans are a big advance over the way we used to check for post-void residual via catheterization," Richards adds.

3. Look at toileting programs and urinary and/or bowel incontinence (Section H). For example, have you checked a toileting program or bladder training at H3a or H3b? If not, would the resident benefit from one to improve his continence and potentially reduce UTIs?

"One of the best ways to prevent UTIs is to implement a toileting program where every resident who is capable of transferring to a toilet or bedside commode empties his or her bladder" on a regular basis and before bed, says **Reta Underwood**, a survey consultant in Buckner, KY. Sitting upright on the commode helps empty the bladder more

completely, which helps prevent retention, she says.

Is the resident incontinent of bowel (H1a)? Facilities need to pay equal attention to bowel incontinence, suggests **Janet Feldkamp, LHNA, RN, JD,** a partner with **Benesch, Friedlander, Coplan & Aronoff LLP** in Columbus, OH. Fecal incontinence can cause UTI and skin breakdown, she says.

Assess Residents With Catheters

Residents with indwelling catheters are often a UTI waiting to happen--or recur. So take a close look at whether long-term use of a catheter (more than 14 days) meets the indications spelled out by the revised F315 survey guidance.

Indications for diagnosing UTI in a resident with an indwelling catheter include at least two of the following signs and symptoms, according to the F315 guidelines:

- fever or chills;

- new flank pain or suprapubic pain or tenderness;

- change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or

- worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present.

Tip: Evaluate residents for use of suprapubic catheters if they require long-term indwelling catheters due to paralysis or other chronic conditions.

4. Check the medication administration record for drugs that can cause urinary retention or incontinence. Anticholinergic medications, including an antihistamine, can lead to urinary retention that puts the resident at higher risk for developing UTI, according to **David Jones, RPh, FASCP**, in Baltimore. In addition, any drug that causes sedation or confusion can cause or exacerbate incontinence. "And if the person wets his pants a little, the urine provides a culture medium where bacteria can grow unchecked," says Jones.