Incontinence - script

Slide 1 My name is Maureen Valvo I am a Sr. Quality Improvement Specialist on the IPRO Nursing Home Team in the Health Care Quality Improvement Department. And I will review the Long Stay Quality Measure the Percent of Low-Risk Residents Who Lose Control of Their Bowels or Bladder.

Slide 2 Objectives:

- Review and Become familiar with the QM specifications
- Understand how MDS coding Sections C: Cognitive Patterns, Section G: Functional Status, Section H: Bladder and Bowel trigger the Incontinent QM
- Last I will discuss the Model for Improvement and Next Steps-how to use this information

Slide 3 This quality measure is a long stay quality measure, meaning cumulative days in facility of more than or equal to 101 days. So if the resident has been in your facility 101 days or more, and that does not include days in and out, possibly back to the hospital, but only counts the days in the facility, then they are going to be in the long stay quality measure of percent of residents with bowel or bladder incontinence.

There are short stay measures based on a calculation that is 100 days or less. But these are mutually exclusive. A resident on any given report is only considered a long stay resident or a short stay resident, but not both for that report.
Slide 4 This Quality Measure is used in the
- CMS CASPER Quality Measure Report,
- Nursing Home Compare, the federal public nursing home website
- Nursing Home Quality Care Collaborative (NHQCC) Composite Measure Score: It is one of the 13 included quality measures
- Reviewed during the Annual Survey process

It is Not one of the 11 QMs in the 5 STAR Rating

Slide 5

URINARY INCONTINENCE IS the involuntary loss of urine.

URINARY CONTINENCE Any void that occurs voluntarily, or as the result of prompted, assisted, or scheduled toileting.

BOWEL INCONTINENCE This includes IN VOLUNTARY incontinence of any amount of stool, day or night.

RAI Manual October 2013 UPDATE Removed toileting sites

DEFINITION OF CONTINENCE WAS prior to 2013 any void into a commode, urinal, bedpan toilet that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Now JUST Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting. The definition No longer indicates WHERE the resident can VOLUNTARILY void.
Slide 6

This is A SCREEN SHOT OF the specification for the QM % of Low-Risk Residents Who Lose Control of Their Bowels or Bladder as displayed in the MDS 3.0 Quality Measures USER’s Manual. I’ll Review item by item starting on the next slide.

Slide 7

The Numerator of the Quality Measure Percent of Low-Risk Residents Who Lose Control of their Bladder OR of Their Bowels is Long-stay residents with a selected target assessment that indicates they are is frequently or always incontinent of bladder or of bowel –I will discuss each of these further.

The Denominator of the Incontinent QM is All Long-stay residents with a selected target assessment, except those with exclusions, leaving only the low risk for incontinence residents in the denominator.

Looking at your CASPER QM report --As Result of the percent of Low-Risk Residents Who INCONTINENT OF BLADDER OR Bowels Exclusions,

The DENOMINATOR is lower than of the total number of long term residents WITH TARGET ASSESSMENTS—

Compare the denominator for the percent of Low-Risk Residents Who Lose Control of Their Bladder OR BLADDER QM with the denominator for the Restraint QM which equals All long-stay residents with a target assessment,

On the next slide I will review the Exclusions.
Slide 8

There are 8 exclusions

#1-admission, and 5 day Medicare PPS are excluded

Or exclusion #2- not in the numerator + data missing on continence status for H0300 bladder or H0400 bowel

Then skipping down to

Or EXCLUSION # 6 on the list is the Resident is comatose or comatose status is missing

Or exclusion #7 resident has an indwelling catheter or the indwelling catheter status is missing

Or Exclusion # 8 residents has an ostomy or ostomy status is missing

Or exclusion #4 - which has 2 options

The first option has 2 requirements

Resident does NOT qualify as high risk [ item # 3] which I will discuss on the next slide - therefore the resident is low risk

AND both of the following are true

MDS item C0500 [the Brief interview for mental status (BIMS)] = 99 unable to complete the interview--^ [caret] = skipped or dash - = not assessed

And ON THE Staff assessment of mental status if the mds item is skipped/not assessed

OR

Staff assessment of Cognitive Skills for Daily Decision Making MDS Item skipped/ not assessed ]
FOR exclusion #5 - if the resident does not qualify as high risk AND ANY ONE OF THE ADL self-performance questions of bed mobility self-performance, transfer self-performance or locomotion on the unit self-performance -- is not assessed

On the next slide I’ll discuss exclusion item # 3- how to identify the resident as high risk for incontinence of Bowel or bladder

Slide 9

Exclusion # 3-Residents are High Risk for incontinence of bladder or bowel if they have ANY OF THE FOLLOWING 4 conditions -

if the resident has severe cognitive impairment or are totally dependent for self performance of bed mobility, or are totally dependent for self performance of transfer, or are totally dependent for self performance of locomotion on the unit

How are these conditions identified?

To accurately identify these high risk conditions – again as always, MDS coding accuracy is critical

For exclusion Item #3a- establishing severe cognitive impairment - >there are two options-

For the first option – there are 2 Qualifiers that must be met—these items are two staff assessment items – if the resident is unable to be interview
The STAFF ASSESSMENT OF Cognitive Skills for Daily Decision Making is SEVERLY IMPAIRED AND
Staff assessment of mental status, short term memory indicates a MEMORY PROBLEM

AND
Secondly for exclusion item #3a must also have a short term memory indicates
The residents is unable to describe an event 5 minutes after it occurred
Or to follow through on a direction given 5 minutes earlier.

OR

For –IF THE RESIDENT IS ABLE TO BE INTERVIEWED -the Brief interview for mental status SUMMARY SCORE IS LESS THAN or = to 7 INDICATING severe impairment

OR

The resident is
TOTALY DEPENDENT BED MOBILITY, self-performance
OR
TOTALY DEPENDENT TRANSFER, self-performance
OR
TOTALY DEPENDENT for LOCOMOTION on the unit – self-performance —

On this slide is also a screenshot of the MDS 3.0 ADL coding instructions for these items

Slide 10 The measure is triggered by either Bladder OR Bowel incontinence, 2 separate MDS questions, so I will review them individually

Slide 9 is a screenshot of the question of Bladder Continence H0300- and coding instructions. There is a 7 day look back. As discussed earlier in the Quality Measure specifications and listed here in italics that Code 2. Frequently Incontinent [if during the 7-day look-back period, the resident was incontinent of urine during seven or more episodes but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.]

Or code 3. Always Incontinent [if during the 7-day look-back period, the resident had no continent voids.] 2 or 3 may Trigger the QM

the other options are 0=always continent; 1=occasionally incontinent that is defined as incontinent less than 7 episodes – during the 7 day look back period
Slide 11

This is screen shot of the MDS question Bowel Continence H0400

Codes 2. Frequently Incontinent or 3. Always Incontinent Trigger the QM

Coding Instructions for bowel

• Code 2, frequently incontinent: if during the 7-day look-back period, the resident was incontinent of bowel more than once, but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.

• Code 3, always incontinent: if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements.

• Code 0, always continent: if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence.

• Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.

SLIDE 12

Steps for Assessment: similar for both questions- to assess that the resident has Bladder Incontinence or Bowel incontinence

1. Review the medical record for incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
Be sure that THE system of documentation includes clear identification of Continent or Incontinent Episodes

[ NOT JUST WET- DRY-OR TRACKING the number of BM]

2. Interview the resident if he or she is capable of reliably reporting his or her continence.

Speak with family members or significant others if the resident is not able to report on continence.

3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Tip:

• Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Slide 13 planning for care-I will discuss bladder and bowel separately
Planning for Care Bladder Incontinence-
Must assess what kind of urinary incontinence- the cause OF THE INCONTINENCE- THIS IS VERY IMPORTANT AND PROPER ASSESSMENT GUIDES SOLUTIONS - 7 day bladder diary For many residents, incontinence can be resolved or minimized by — identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, stool impaction, and immobility (especially among those with the new or recent onset of incontinence);

Type of incontinence Urinary Incontinence” is the involuntary loss or leakage of urine.

Briefly - There are several types of urinary incontinence, and the individual resident may experience more than one type at a time. Some of the more common types include:
Stress Incontinence occurs with coughing, sneezing, laughing, lifting, standing from a sitting position, climbing stairs,

Urge incontinence due to an overactive or spastic bladder, a sudden, strong urge to expel moderate to large amounts of urine before the bladder is full.

Mixed is a combination-stress incontinence with urgency

Overflow due to blocked urethra or weak bladder muscles leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended.

Transient temporary/occasional related to a potentially improvable/reversible cause.

Functional can’t get to toilet in time due to physical disability, external obstacles, or problems thinking or communicating, or availability of staff assistance.

Urinary continence improvement strategies are

**BLADDER REHABILITATION/ BLADDER RETRAINING**
resist or inhibit the desire to urinate, to postpone or delay voiding, to urinate according to a timetable to improve muscle tone.

**PROMPTED VOIDING** regular monitoring, using a schedule and prompting the resident to toilet.

**HABIT TRAINING/ SCHEDULED VOIDING** toileting on a planned basis to match the resident’s voiding habits or needs.

Under resources are listed further information on implementing guides which include sample tools to identify Toileting-Preference, a Bladder Diary Prompted Voiding Trail, Behavioral Interventions, Incontinence Medical Record Review
Slide 14  Bowel incontinence- Planning for Care

• For many residents, bowel incontinence can be resolved or minimized by — identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility, diet, (especially among those with the new or recent onset of incontinence); and

— eliminating environmental physical barriers to accessing toilets, commodes, bedpans, and staff availability for toileting assistance – A schedule helps both staff and resident

Again Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

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Slide 15

Here is a screen shot of the CASPER QM facility level report-  QM resulting from the MDS coding on the discussed MDS questions is captured on a facility level

On the Casper Report the residents that actually triggered are in the numerator. Compared against the state average and the national average. The last column is the national percentile ranking. Possibly an opportunity for improvement. Remember, for quality measure, getting closer to 0 the better.

Exclusions: DETAILS PREVIOUSLY DISCUSSED

On this report 18 low risk residents are incontinent of bowel or bladder of the 22 identified as low risk – I will discuss how to use this data to identify areas for improvement- but look at your nursing homes casper report equals this denominator for Low risk residents is much lower than the other denominators. Why are these low risk residents incontinent?

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Slide 16

Here is a screen shot of the CASPER QM Resident level report

On the highlighted a Residents Quarterly MDS, the Resident triggers for incontinence, as well as falls, Antipsychotic meds, behaviors symptom affecting others-

Which QM was triggered first- Root Cause analysis -did behaviors lead to inappropriate use of antipsychotic medications, sedating resident and resulting in falls and incontinence- Review residents medical record and talk to staff to identify areas for improvement and education LOOKING AT ALL THE RESIDENTS THAT TRIGGER INCONTINENCE THERE MAY BE OTHER COMMON TRIGGERS- QUESTION THE CORRELATION

Slide 17  for review -

Incontinence Improvement Strategies:

- Assessment of Cause of Urinary or Bowel Incontinence
- Staff Education
- Consistent Assignment
- Individual toileting program
- Accurate Tracking /Documentation
- Clear Documentation of Continence /Incontinent Status
- Documentation/ Progress Notes reference Care Plan

Slide 18 Model for Improvement - Next Steps

Analyze the data --Use QM reports— ON THE QM report 18 low risk residents are incontinent of bowel or bladder of the 22 identified as
Incon script

low risk – - THE ONE RESIDENT highlighted a Residents LEVEL REPORT triggers for incontinence, as well as falls, Antipsychotic meds, behaviors symptom affecting others-

REVIEW THE RESIDENTS RECORD to determine a root cause or IDENTIFY A quality improvement opportunity- use concurrent data monitoring as you work through your quality improvement process.

Beginning with all MDS coding Accuracy issues-

Utilizing the 5 whys

Drill the information down to the resident level and the Interdisciplinary Team review and assess the residents that are triggering the QM
Check for MDS coding errors (point and click) Be sure that there is not an electronic entry error Assess MDS Coding accuracy/inaccuracy based on Review of the Quality Measure specifications, Quality Measure User Manual, and MDS 3.0 RAI Manual to ensure that coding is accurate. Verify medical record documentation supports coding related to the Assessment Reference Date (ARD).
Assess the experience of interviewers and effect(s) of flawed interview skill/technique accurately evaluating cognitive status and memory.
Assess the effect of staff stability/consistent assignment practice with providing assistance and evaluating toileting issues and identifying toileting needs

Develop individualized care plans -- QI Closest to the Resident-consistent assignment- input of primary aide on each shift Measure overall effectiveness of QI interventions

Need to understand, how do we even have this problem, and what is a system failure that’s leading to this issue for our residents. When did that performance not meet expectations, or how does it not meet the expectations? There could be many reasons for the potential incontinence
Plan for improvement:
So what are we trying to accomplish?
And then what change can we make that will result in an improvement?  
How will we know that the change is an improvement?  
PLAN DO STUDY ACT model-test of change  
Was that test of change successful?  
Do we need to do something different?  
Do we need to test it further?

SLIDE 19

The RESOURCES used for this presentation and available on our website.

- RAI Manual Ch.3 Section H: Bowel and Bladder Section C: Cognitive Pattern; and Section G: ADL
- Incontinence Care Area Assessment (CAA) – Guides A RESIDENT REVIEW
- Critical Elements for Urinary Incontinence – recommend General Pathway for Bowel incontinence

- Additional RESEARCH- Vanderbilt Incontinence Management Module for evaluation, assessment, and interventions

Providing TOOLS
- Toileting-Preference, Bladder Diary Prompted Voiding Trail, Behavioral Interventions, Incontinence Medical Record Review

SLIDE 20 The last slide is our Contact info and web address. Please call or e-mail us with any questions. Thank You.