

CHAPTER 6 – SECTION G

PERCENT OF LOW-RISK RESIDENTS WHO LOSE CONTROL OF THEIR BOWELS OR BLADDER

NOTE: This measure is reported on Nursing Home Compare as a paired measure, in conjunction with the chronic care indwelling catheter quality measure. Therefore, if either measure is selected on Nursing Home Compare, both measures will be displayed.

QM Description

This measure reflects the percent of low-risk residents who often lose control of their bowels or bladder. Low-risk is defined as residents who do not have severe dementia, and do not have limited ability to move on their own.

Rationale for Incontinence QM

Loss of bowel or bladder control is not a normal part of aging and can often be successfully treated in cognitively intact residents. The impact of incontinence profoundly affects residents as well as staff. Incontinence can cause feelings of shame and embarrassment for the resident, and increases the burden of care for caregivers. Incontinence may be caused by the use of restraints, changes in medications, presence of infections, or changes in a resident's physical status. Many individuals view incontinence as an inevitable condition of aging, however many effective treatments are available. Individualized programs should focus on evaluation of residents to identify potential causes, documentation, care planning, early intervention, and education. Additional information about this clinical condition, as well as quality improvement strategies, can be found on CMS's website at www.MedQIC.org.

MDS Assessments Used

- **Target assessment:** OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.

QM Specifications

NUMERATOR

Residents who were frequently incontinent or fully incontinent on the target assessment (H1a = 3 or 4 for bowel incontinence, or H1b = 3 or 4 for bladder incontinence).

DENOMINATOR

All residents with a valid target assessment after exclusions are applied and not qualifying as high risk.

RISK ADJUSTMENT STRATEGIES USED

Exclusion....Yes Stratification....Yes Regression....No

EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

1. Residents who qualify as high risk are excluded from the denominator:
 - a. Severe cognitive impairment on the target assessment as indicated by B4 = 3 AND B2a = 1; *OR*
 - b. Totally dependent in mobility ADLs on the target assessment: (G1a(A) = 4 or 8 AND G1b(A) = 4 or 8 AND G1e(A) = 4 or 8).
2. Residents satisfying any of the following conditions are also excluded from the denominator:
 - a. The target assessment is an admission (AA8a = 01) assessment.
 - b. The QM did not trigger (resident is not included in the QM numerator) AND the value of H1a or H1b is missing on the target assessment.
 - c. Residents who are comatose (B1 = 1) or comatose status are unknown (B1 = missing) on the target assessment.
 - d. The resident has an indwelling catheter (H3d = checked) or indwelling catheter status is unknown (H3d = missing) on the target assessment.
 - e. The resident has an ostomy (H3i = checked) or ostomy status is unknown (H3i = missing) on the target assessment.
 - f. The resident does not qualify as high risk and the cognitive impairment items (B2a or B4) are missing on the target assessment.
 - g. The resident does not qualify as high risk and any of the mobility ADLs [G1a(A), G1b(A) and G1e(A)] are missing on the target assessment.

STRATIFICATION

This measure is stratified into high and low risk groups, however, only the low risk group is calculated and reported for the quality measures.

COVARIATES USED IN REGRESSION

No covariates are used in calculation of the incontinence quality measure.

MDS Elements Related to QM

H1a Bowel Continence –Refers to control of bowel movement and resident’s bowel continence pattern.

H1b Bladder Continence – Refers to control of bladder function and resident’s bladder continence pattern.

B4 Cognitive Skills for Daily Decision Making – The resident’s actual performance in making everyday decisions about tasks or activities of daily living.

B2a Short-Term Memory- The resident’s functional capacity to remember both recent events (e.g., remembering multiple items over time or following through on a direction given five minutes earlier).

G1a (A) Bed Mobility Self-Performance - How the resident moves to and from lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the resident sleeps in, rather than a bed.

G1b (A) Transfer Self-Performance - How the resident moves between surfaces – i.e., to/from: bed, chair, wheelchair, standing position Exclude from this definition movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

G1e (A) Locomotion on Unit Self-Performance - How the resident moves between locations in his/her room and adjacent corridor on same floor. If the resident is in a wheelchair, locomotion is defined as self-sufficiency once in the chair.

B1 Comatose – The resident has been diagnosed as comatose or in a persistent vegetative state.

H3d Indwelling catheter – A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

H3i Ostomy – Any type of excretory ostomy of the gastrointestinal or genitourinary tract.

MDS RAI Coding Instructions

SECTION H. CONTINENCE IN LAST 14-DAYS

CMS's RAI Version 2.0 Manual

CH 3: MDS Items [H]

SECTION H. CONTINENCE IN LAST 14 DAYS

H1. Continence Self-Control Categories (14-day look back)

Note: This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days. The 14-day period allows many opportunities for assessment, but it is acceptable to establish voiding patterns in shorter periods of time.

Intent: To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

Definition: (a.) Bowel Continence and (b.) Bladder Continence

Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self - e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The resident's self-performance in toilet use is recorded in Item G1Ai.

Process: Review the resident's clinical record and any urinary or bowel elimination flow sheets (if available). Validate the accuracy of written records with the resident. Make sure that your discussions are held in private. Control of bladder function and bowel function are sensitive subjects, particularly for residents who are struggling to maintain control. Many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they mistakenly believe that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

- Determination of whether or not to code incontinence is not a matter of volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown. According to Dr. Courtney Lyder, Ph.D. a nationally recognized incontinence and pressure ulcer expert from Yale University School of Nursing, "Urinary incontinence is a major risk factor for pressure ulcer development. Hence excessive moisture (from stool and/or urofecal incontinence) can cause the skin to become macerated with less pressure

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needed to develop a Stage II pressure ulcer. In the presence of moisture, less pressure may be required to develop an ulcer.” Coding incontinence is a matter of acknowledging and recording a resident’s incontinence problem on the assessment, and ensuring that the care plan derived from the assessment addresses the problem. If the resident’s skin gets wet with urine, or if whatever is next to the skin (i.e., pad, brief, underwear) gets wet, it should be counted as an episode of incontinence - even if it’s just a small volume of urine, for example, due to stress incontinence. Any episode of incontinence requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care plan. In addition, since incontinence is a problem that many residents are sensitive about, intervention involves maintaining dignity and life-style.

- Validate continence patterns with people who know the resident well (e.g., primary family caregiver of newly admitted resident; direct care staff).
- Remember to consider continence patterns over the last 14-day period, 24 hours a day, including weekends. If staff assignments change frequently, consider initiating and maintaining a bladder and bowel elimination flow sheet in order to gather more accurate information as a basis for coding decisions and, ultimately, care planning.
- The keys to obtaining, tracking and recording accurate information in this section are 1) interviews with and observations of residents, and 2) communication between licensed and non-licensed staff and other caregivers.
 - Daily communication between nurses, certified nurse assistants (CNAs) and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area. Staff who work most closely with residents will know how often they are dry or wet.
 - Focus your assessment over the last 14 days. When getting information about continence from CNAs, start to narrow your questions to focus on either end of the continence scale, then work your way to the middle. For example using the urinary continence scale, if the resident is always dry, code “0” (Continent). If the resident is always wet, and has no control, code “4” (Incontinent). If incontinence occurs only once a week or less, code “1” (Usually continent). The difference between code “2” (Occasionally incontinent), and code “3” (Frequently incontinent) is that for code “3”, the resident is incontinent at least daily or multiple times a day.

Coding: A five-point coding scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The reason for these differences is that there are more

episodes of urination per day and week, whereas bowel movements typically occur less often.

- 0. Continent** - Complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).
- 1. Usually Continent** - Bladder, incontinent episodes occur once a week or less; Bowel incontinent episodes occur less than once a week.
- 2. Occasionally Incontinent** - Bladder incontinent episodes occur two or more times a week but not daily; Bowel incontinent episodes occur once a week.
- 3. Frequently Incontinent** - Bladder incontinent episodes tend to occur daily, but some control is present (e.g., on day shift); Bowel incontinent episodes occur two to three times per week.
- 4. Incontinent** - Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern - i.e., the frequency with which the resident is wet and dry during the 14-Day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

To ensure accurate coding in H1a and H1b, assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct care staff across all shifts.

Examples of Bladder Continence Coding

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. **Code "0" for "Continent" - Bladder.**

Mr. R had an indwelling catheter in place during the entire 14-Day assessment period. He was never found wet and is considered continent. **Code a "0" for "Continent" - Bladder.**

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. **Code "1" for "Usually Continent" - Bladder.**

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. **Code "2" for "Occasionally Incontinent" - Bladder.**

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. **Code "3" for "Frequently Incontinent" - Bladder.**

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. **Code "4" for "Incontinent" - Bladder.**

H2. Bowel Elimination Pattern (14-day look back)

Intent: To record the effectiveness of resident's bowel function.

- Definition:*
- a. **Bowel Elimination Pattern Regular** - Resident has at least one movement every three days.
 - b. **Constipation** - Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.
 - c. **Diarrhea** - Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).
 - d. **Fecal Impaction** - The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on an abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.