CHAPTER 6 – SECTION H

PERCENT OF RESIDENTS WHO HAVE/HAD A CATHETER INSERTED AND LEFT IN THEIR BLADDER

NOTE: *This measure is reported as a paired measure, in conjunction with the chronic care incontinence 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 residents who had a catheter inserted and left in their bladder for a period of time during the 14-day assessment period.

Rationale for Indwelling Catheter QM

Catheters are commonly used for urinary retention, wound management, and in certain circumstances, patient comfort. Unfortunately catheters may be used for incontinence control as a convenience rather than medical necessity. Catheters place residents at a higher risk for hospitalizations, infections, greater length of stay, and delirium. When not properly maintained and monitored, indwelling catheters can cause chronic pain and/or infections leading to a greater functional decline and decreased quality of life for the resident. Toileting programs and thorough assessment of the resident can sometimes decrease or prevent the use of catheters. Additional information related to the use of indwelling catheters, 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 facility's measure calculations.
- **Prior assessment**: AA8a = 01, 02, 03, 04, 05, or 10. Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date. Prior assessments are used for covariate calculations.

QM Specifications

NUMERATOR
Residents with indwelling catheters on the target assessment (H3d is checked).

DENOMINATOR
All residents with a valid target assessment after exclusions are applied.

RISK ADJUSTMENT STRATEGIES USED
Exclusions….Yes Stratification….No Regression….Yes

EXCLUSIONS
Residents satisfying any of the following conditions are excluded:

- The target assessment is an admission (AA8a = 01) assessment.
- H3d is missing on the target assessment.

COVARIATES USED IN REGRESSION
Clinical Covariates:

1. Indicator of bowel incontinence on the prior assessment:
   Covariate = 1* if H1a = 4
   Covariate = 0* if H1a = 0, 1, 2, or 3

2. Indicator of pressure sores on the prior assessment:
   Covariate = 1* if M2a = 3 or 4
   Covariate = 0* if M2a = 0, 1, or 2

   *If covariate = 1, the covariate is present and it contributes to the risk-adjustment. If covariate = 0, the covariate is not present and therefore does not contribute to the risk-adjustment.

See Chapters 4 and 5 for more information on risk adjustment and the use of covariates.

MDS Elements Related to QM

H3d Appliances and Programs - Indwelling catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

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

M2a Type of Ulcer – Presence of Stage 1-4 pressure ulcers.

MDS RAI Coding Instructions

SECTION H. CONTINENCE IN LAST 14 DAYS

NOTE: MDS ITEMS THAT DO NOT TRIGGER THE QUALITY MEASURES ARE INTENTIONALLY IN GRAY TEXT.

H3. Appliances and Programs (14-day look back)

Definition:

a. **Any Scheduled Toileting Plan** - A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

b. **Bladder Retraining Program** - A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

c. **External (Condom) Catheter** - A urinary collection appliance worn over the penis.

d. **Indwelling Catheter** - A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

e. **Intermittent Catheter** - A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder-emptying program (e.g., every shift in a resident with an under active or a contractile bladder muscle).

f. **Did Not Use Toilet Room/Commode/Urinal** - Resident never used any of these items during the last 14 days, nor used a bedpan.

g. **Pads/Brief Used** - Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., incontinence garments, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

h. **Enemas/Irrigation** - Any type of enema or bowel irrigation, including ostomy irrigations.

i. **Ostomy Present** - Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.

j. *NONE OF ABOVE (Not Used on the MPAF)*

Process: Check the clinical record. Consult with the nurse assistant and the resident. Be sure to ask about any items that are hidden from view because they are worn under clothing (e.g., pads or briefs).

Coding: Check all that apply. These items should be coded if a resident has, or has had any of the items during the 14-day observation period. Items that were in use during the observation period but were discontinued should be included. For example, if the resident had an indwelling catheter at the beginning of the observation period and it was later discontinued, the indwelling catheter would be coded. If none of the items apply, check *NONE OF ABOVE*.

Clarifications:

- There are 3 key ideas captured in Item H3a: 1) scheduled, 2) toileting, and 3) program. The word "scheduled" refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers. The concept of "toileting" refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle (i.e., urinal, bedpan). Changing wet garments is not included in this concept. A "program" refers to a specific approach that is organized, planned, documented, monitored and evaluated. A scheduled toileting program could include taking the resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void.

  If the scheduled plan is recorded in the care plan and staff are actually toileting the resident according to the multiple specified times, check Item H3a. If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, reversible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause. Also determine whether or not there is a pattern to the extra times the resident is incontinent and consider adjusting the scheduled toileting plan accordingly.

  For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. If the care plan is the resource used by staff to be made aware of resident's specific toileting schedules, then the toileting schedule should appear there. Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each day. If the timing of such routines is not fairly standardized, specific times should then be noted. Documentation in the clinical record should evaluate the resident's response to the toileting program.

  Feeding tubes/gastrostomies are coded in Sections K and P. Only appliances used for elimination are coded here.