



Bowel and Bladder Program for Skilled Nursing Facilities

January 2022

RBHP Bowel and Bladder Program

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MEMORANDUM OF DIRECTION

DATE:

TO: All Nursing staff

FROM: Director of Nursing

SUBJECT: Bowel and Bladder Program

All residents admitted to facility will have a Bowel and Bladder Continence Evaluation performed at the time of admission, in conjunction with each quarterly and annual assessment, with any significant change assessment and as deemed necessary by the Interdisciplinary Team; this includes the removal of an indwelling urinary catheter.

The admitting nurse or designee is responsible for completing the initial evaluation. The admitting nurse or designee will then be responsible for initiating the 5-Day Resident Tracking/Trending Bowel and Bladder Pattern in the electronic medical record for all new admissions. The C.N.A. responsible for the resident at the time of admission will begin the tracking and trending within the electronic medical record.

After the 5 days the DON or designee will review the documentation looking for an established pattern. The DON or designee along with the Interdisciplinary Team will evaluate the appropriate program for the resident and refer to Restorative if appropriate. When appropriate, the DON or designee will initiate the Restorative Bowel and/or Bladder Retraining Program. This is a 14-day program.

The DON or designee will assign tasks within the electronic medical record for toileting times identified during the 5-day tracking/trending of incontinence; this will alert the C.N.A. to toilet one hour prior to attempt retraining. After 14 days the Unit Manager or designee will reevaluate the appropriateness to continue with current plan or change the current plan.

F690

Quality of Care

§483.25(e)(1)-(3)

Bowel/Bladder Incontinence, Catheter, UTI

Survey Regulations & Interpretive Guidelines

F690

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(e) Incontinence.

§483.25(e)(1) *The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.*

§483.25(e)(2) *For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that—*

- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;*
- (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and*
- (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.*

§483.25(e)(3) *For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.*

INTENT

The intent of this requirement is to ensure that:

- Each resident who is continent of bladder and bowel receives the necessary services and assistance to maintain continence, unless it is clinically not possible.*
- Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal bladder function as possible;*
- A resident who is incontinent of bowel is identified, assessed and provided appropriate treatment and services to restore as much normal bowel function as possible;*
- An indwelling catheter is not used unless there is valid medical justification for catheterization and the catheter is discontinued as soon as clinically warranted;*
- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the indwelling catheter; and*
- A resident, with or without an indwelling catheter, receives the appropriate care and services to prevent urinary tract infections to the extent possible.*

DEFINITIONS

“Bacteremia” is the presence of bacteria in the bloodstream.

“Bacteriuria” is defined as the presence of bacteria in the urine.

“Contenance” refers to any void that occurs voluntarily, or as the result of prompted, assisted, or scheduled use of the bathroom.

“Sepsis” is the body’s overwhelming and life-threatening response to an infection which can lead to tissue damage, organ failure, and death.

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

“Urinary Retention” is the inability to completely empty the urinary bladder by micturition.

“Urinary Tract Infection (UTI)” is a clinically detectable condition associated with invasion by disease causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (ureteritis), and/or kidney (pyelonephritis). An infection of the urethra or bladder is classified as a lower tract UTI and infection involving the ureter or kidney is classified as an upper tract UTI.

GUIDANCE §483.25(e)

A resident who is continent of bladder on admission must receive care, including assistance, and services to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. If a resident is admitted with incontinence of bladder, he/she receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Urinary incontinence generally involves a number of transitory or progressive factors that affect the bladder and/or the urethral sphincter. Any condition, medication, or factor that affects lower urinary tract function, bladder capacity, urination, or the ability to toilet can predispose residents to urinary incontinence and may contribute to incomplete bladder emptying.

Assessment

A resident should be assessed at admission regarding continence status and whenever there is a change in urinary tract function, such as if a resident is admitted who is continent of urine, and subsequently becomes incontinent. The identification of reversible and irreversible (e.g., bladder tumors, spinal cord disease) causes of incontinence, including the type of incontinence, provides direction for the development of appropriate interventions. It is important that staff, when completing the comprehensive assessment, consider the following:

- Prior history of bladder functioning, including status of continence, history of urinary incontinence, including onset, duration and characteristics, precipitants of urinary incontinence, associated symptoms (e.g., dysuria, polyuria, hesitancy) and previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI;

- *Voiding patterns (such as frequency, volume, nighttime or daytime, quality of stream) and, for those already experiencing urinary incontinence, voiding patterns over several days;*
- *Medication review, particularly those that might affect continence, such as medications with anticholinergic properties (may cause urinary retention and possible overflow incontinence), sedative/hypnotics (may cause sedation leading to functional incontinence), diuretics (may cause urgency, frequency, overflow incontinence), narcotics, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) calcium channel blockers (may cause urinary retention);*
- *Patterns of fluid intake, such as amounts, time of day, alterations and potential complications, such as decreased or increased urine output;*
- *Use of urinary tract stimulants or irritants (e.g., frequent caffeine intake);*
- *Pelvic and rectal examination to identify physical features that may directly affect urinary continence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, use of a urinary catheter, atrophic vaginitis, distended bladder, or bladder spasms;*
- *Functional and cognitive capabilities that could enhance urinary continence and limitations that could adversely affect continence, such as impaired cognitive function or dementia, impaired immobility, decreased manual dexterity, the need for task segmentation, decreased upper and lower extremity muscle strength, decreased vision, pain with movement;*
- *Type and frequency of physical assistance necessary to assist the resident to access the toilet, commode, urinal, etc. and the types of prompting needed to encourage urination;*
- *Pertinent diagnoses such as congestive heart failure, stroke, diabetes mellitus, obesity, and neurological disorders (e.g., Multiple Sclerosis, Parkinson's Disease or tumors) that could affect the urinary tract or its function);*
- *Identification of and/or potential of developing complications such as skin irritation or breakdown;*
- *Tests or studies indicated to identify the type(s) of urinary incontinence (e.g., post-void residual(s) for residents who have, or are at risk of, urinary retention, results of any urine culture if the resident has clinically significant systemic or urinary symptoms), or evaluations assessing the resident's readiness for bladder rehabilitation programs; and*
- *Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet (e.g., grab bars, raised or low toilet seats, inadequate lighting, distance to toilet or bedside commodes, and availability of urinals, use of bed rails or restraints, or fear of falling).*

Types of Urinary Incontinence

Identifying the nature of the incontinence is a key aspect of the assessment and helps identify the appropriate program/interventions to address incontinence. 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:

- **Urge Incontinence** is associated with detrusor muscle over activity (excessive contraction of the smooth muscle in the wall of the urinary bladder) resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full). It is characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). It may be age-related or have neurological causes (e.g., stroke, diabetes mellitus, Parkinson's disease, multiple sclerosis) or other causes such as bladder infection, urethral irritation, etc. The resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode. It is the most common cause of urinary incontinence in elderly persons.
- **Stress Incontinence** (outlet incompetence) is associated with impaired urethral closure (malfunction of the urethral sphincter) which allows small amounts of urine leakage when intra-abdominal pressure on the bladder is increased by sneezing, coughing, laughing, lifting, standing from a sitting position, climbing stairs, etc. . Urine leakage results from an increase in intra-abdominal pressure on a bladder that is not over distended and is not the result of detrusor contractions. It is the second most common type of urinary incontinence in older women.
- **Mixed Incontinence** is the combination of urge incontinence and stress incontinence. Many elderly persons (especially women) will experience symptoms of both urge and stress.
- **Overflow Incontinence** is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended from urine retention. Symptoms of overflow incontinence may include: weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling. Urine retention may result from outlet obstruction (e.g., benign prostatic hypertrophy (BPH), prostate cancer, and urethral stricture), hypotonic bladder (detrusor under activity) or both. Hypotonic bladder may be caused by outlet obstruction, impaired or absent contractility of the bladder (neurogenic bladder) or other causes. Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury, or pelvic nerve damage from surgery or radiation therapy. In overflow incontinence, post void residual (PVR) volume (the amount of urine remaining in the bladder within 5 to 10 minutes following urination) exceeds 200 milliliters (ml). Normal PVR is usually 50 ml. or less. A PVR of 150 to 200 may suggest a need for retesting to determine if this finding is clinically significant. Overflow incontinence may mimic urge or stress incontinence but is less common than either of those.
- **Functional Incontinence** refers to loss of urine that occurs in a resident whose urinary tract function is sufficiently intact that he/she should be able to maintain continence, but who cannot remain continent because of external factors other than inherently abnormal urinary tract function. Examples may include the failure of staff to respond to a request for assistance to the toilet, or the inability to utilize the toilet facilities in time. It may also be related to:

- *Physical weakness or poor mobility/dexterity (e.g., due to poor eyesight, arthritis, deconditioning, stroke, contracture);*
- *Cognitive problems (e.g., confusion, dementia, unwillingness to toilet);*
- *Medications (e.g., anti-cholinergics, diuretics); or*
- *Environmental impediments including excessive distance from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access.*

Refer to §483.10(e) (3), F558, Accommodation of Needs for issues regarding unmet environmental needs (e.g., handicap toilet, lighting, assistive devices.

NOTE: *Treating the physiological causes of incontinence, without attending to functional components that may have an impact on the resident's continence, may fail to solve the incontinence problem.*

- ***Transient Incontinence*** *refers to temporary or occasional incontinence that may be related to a variety of causes, for example: delirium, infection, atrophic urethritis or vaginitis, some pharmaceuticals (such as sedatives/hypnotics, diuretics, anticholinergic agents), increased urine production, restricted mobility or fecal impaction. The incontinence is transient because it is related to a potentially improvable or reversible cause.*

Interventions

A number of factors may contribute to the development of incontinence, or decline or lack of improvement in urinary continence, such as an underlying medical condition, an inaccurate assessment of the resident's type of incontinence, or lack of knowledge about the resident's voiding patterns. This may contribute to inappropriate interventions or unnecessary use of an indwelling catheter. Facility practices that may promote achieving the highest practicable level of functioning, may prevent the development of incontinence, or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as:

- *Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc.;*
- *Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet);*
- *Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion);*
- *Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and*
- *Implementing a fluid and/or bowel management program to meet the assessed needs.*

Options for managing urinary incontinence in nursing home residents include primarily behavioral programs and medication therapy. Other measures and supportive devices used in the management of urinary incontinence and/or urinary retention may include intermittent catheterization; pelvic organ support devices (pessaries); biofeedback; the use of incontinence

products, garments and an external collection system for men and women; and environmental accommodation and/or modification.

Behavioral Programs

Interventions involving the use of behavioral programs are among the least invasive approaches to address urinary incontinence and have no known adverse complications. Behavior programs involve efforts to modify the resident's behavior and/or environment. Critical aspects of a successful behavioral program include education of the caregiver and the resident, availability of the staff and the consistent implementation of the interventions.

NOTE: *It is important for the comprehensive assessment to identify the essential skills the resident must possess, such as the resident's ability to: comprehend and follow instructions; identify urinary urge; control the urge to void until reaching a toilet; and/or respond to prompts to void. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate planning care to avoid or reduce the frequency of episodes.*

Programs that require the resident's cooperation and motivation in order for learning and practice to occur include the following:

- ***“Bladder Rehabilitation/Bladder Retraining”*** *is a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void. Depending upon the resident's successful ability to control the urge to void, the intervals between voiding may be increased progressively. Bladder training generally consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This program is difficult to implement in cognitively impaired residents and may not be successful in frail, elderly, or dependent residents. The resident who may be appropriate for a bladder rehabilitation (retraining) program is usually fairly independent in activities of daily living, has occasional incontinence, is aware of the need to urinate (void), may wear incontinence products for episodic urine leakage, and has a goal to maintain his/her highest level of continence and decrease urine leakage. Successful bladder retraining usually takes at least several weeks. Residents who are assessed with urge or mixed incontinence and are cognitively intact may be candidates for bladder retraining. This is not to be confused with habit training/scheduled voiding (see below); and*
- ***“Pelvic Floor Muscle Rehabilitation,”*** *also called Kegel and pelvic floor muscle exercise, is performed to strengthen the voluntary periurethral and perivaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs. These exercises are helpful in dealing with urge and stress incontinence. Pelvic floor muscle exercises (PFME) strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment of stress urinary incontinence. PFME requires residents who are able and willing to participate and the implementation of careful instructions and monitoring provided by the facility. Poor resident adherence to the exercises may occur even with close monitoring.*

Programs that are dependent on staff involvement and assistance, as opposed to resident function, include the following:

- **“Prompted Voiding”** *is a behavioral technique appropriate for use with dependent or more cognitively impaired residents. Prompted voiding has three components: regular monitoring with encouragement to report continence status; prompting to toilet on a scheduled basis; and praise and positive feedback when the resident is continent and attempts to toilet. These methods require training, motivation and continued effort by the resident and caregivers to ensure continued success. Prompted voiding focuses on teaching the resident, who is incontinent, to recognize bladder fullness or the need to void, to ask for help, or to respond when prompted to toilet.*

Residents who are assessed with urge or mixed incontinence and are cognitively impaired may be candidates for prompted voiding. As the resident’s cognition changes, the facility should consider other factors, such as mobility, when deciding to conduct a voiding trial to determine feasibility of an ongoing program to use the bathroom; and

- **“Habit Training/Scheduled Voiding”** *is a behavioral technique that calls for scheduled use of the bathroom at regular intervals on a planned basis to match the resident’s voiding habits. Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges. This is not considered to be a bladder rehabilitation/retraining program. Habit training includes timed voiding with the interval based on the resident’s usual voiding schedule or pattern. Scheduled voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.*

Intermittent Catheterization

Sterile insertion and removal of a catheter through the urethra every 3-6 hours for bladder drainage may be appropriate for the management of acute or chronic urinary retention. See additional discussion below in “Catheterization”.

Medication Therapy

Medications are often used to treat specific types of incontinence, including stress incontinence and those categories associated with an overactive bladder, which may involve symptoms including urge incontinence, urinary urgency, frequency and nocturia. The current literature identifies classifications and names of medications used for various types of incontinence. When using medications, potentially problematic anticholinergic and other side effects must be recognized. The use of medication therapy to treat urinary incontinence may not be appropriate for some residents because of potential adverse interactions with their other medications or other co-morbid conditions. The resident/representative must be provided with the risks and benefits of using medications for continence management.

Pessary

A pessary is an intra-vaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs. Women whose urine retention or urinary incontinence is exacerbated by bladder or uterine prolapse may benefit from placement of a pessary. Female residents may be admitted to the nursing home with a pessary device. The assessment should note whether the resident has a

pessary in place or has had a history of successful pessary use. If a pessary is used, the plan of care must address the use, care and ongoing management of the pessary including monitoring for complications.

Absorbent Products, Devices, and External Collection Devices

Absorbent incontinence products include perineal pads or panty liners for slight leakage, undergarments and protective underwear for moderate to heavy leakage, guards and drip collection pouches for men, and products (called adult briefs) for moderate or heavy loss. Absorbent products can be a useful, rational way to manage incontinence; however, every absorbent product has a saturation point. Factors contributing to the selection of the type of product to be used should include the severity of incontinence, gender, fit, and ease of use.

Advantages of using absorbent products to manage urinary incontinence include the ability to contain urine (some may wick the urine away from the skin), provide protection for clothing, and preserve the resident's dignity and comfort.

NOTE: *Although many residents have used absorbent products prior to admission to the nursing home and the use of absorbent products may be appropriate, absorbent products should not be used as the primary long term approach to continence management until the resident has been appropriately evaluated and other alternative approaches have been considered.*

It is important that residents using various devices, absorbent products, external collection devices, etc., be checked (and changed as needed) on a schedule based upon the resident's voiding pattern, professional standards of practice, and the manufacturer's recommendations.

Skin-Related Complications

Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning. For a resident with an external catheter, compromise to the skin may also occur.

One form of early skin breakdown is maceration or the softening of tissue by soaking. Macerated skin has a white appearance and a very soft, sometimes "soggy" texture. The persistent exposure of perineal skin to urine and/or feces can irritate the epidermis and can cause severe dermatitis, skin erosion and/or ulcerations. Skin erosion is the loss of some or all of the epidermis (comparable to a deep chemical peel) leaving a slightly depressed area of skin.

Because frequent washing with soap and water can dry the skin, the use of a perineal rinse may be indicated.

CATHETERIZATION

§483.25(e)(2)(i), Incontinence, requires that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; or that a resident who enters the facility with an indwelling urinary catheter, or subsequently receives one is assessed for removal of the catheter as soon as

possible unless the resident's clinical condition demonstrates that catheterization is necessary. The facility is responsible for the assessment of the resident at risk for urinary catheterization and/or the ongoing assessment for the resident who currently has a catheter, including the removal of the catheter when the resident's clinical condition demonstrates the catheter is no longer necessary. While the use of a catheter may promote skin integrity and assessment of output, it is also associated with the increase risk of catheter associated urinary tract infections (CAUTI), including the development of sepsis.

A catheter that is used for appropriate indications and in a dignified manner may enhance an individual's independence and dignity. Conversely, an improperly or indiscreetly used catheter may negatively impact independence and dignity.

NOTE: *For concerns related to the care for a resident with a urostomy or nephrostomy, refer to §483.25(f) - Colostomy, urostomy, or ileostomy care at tag F691.*

In addition, according to the Centers for Disease Control and Prevention (CDC), the definition of a suprapubic catheter is one that "is surgically inserted into the bladder through an incision above the pubis. For care of a resident with a suprapubic catheter, refer to current professional guidelines such as the following;

http://c.ymcdn.com/sites/www.wocn.org/resource/resmgr/publications/Care_&_Mgmt_Pts_w_Urinary_Ca.pdf

Assessment

Regardless of the admission status, a comprehensive assessment should address those factors that predispose the resident to the development of urinary incontinence and the use of an indwelling urinary catheter. An admission evaluation of the resident's medical history and a physical examination helps identify the resident at risk for requiring the use of an indwelling urinary catheter. This evaluation is to include detection of reversible causes of incontinence and identification of individuals with incontinence caused by conditions that may not be reversible, such as bladder tumors and spinal cord diseases.

The assessment of continence/incontinence is based upon a comprehensive, interdisciplinary review and assessment. The comprehensive assessment should include identifying the underlying factors which support the clinical indication for the initiation and continuing need for catheter use, determination of which factors can be modified or reversed (or rationale for why those factors should not be modified), and the development of a plan for removal. The clinician's decision to use an indwelling catheter in the elderly should be based on valid clinical indicators.

For the resident with an indwelling catheter, the facility's documented assessment and staff knowledge of the resident should include information to support the use of an indwelling catheter. Because of the risk of substantial complications with the use of indwelling urinary catheters, they should be reserved primarily for short-term decompression of acute urinary retention. The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort and bleeding.

Intermittent Catheterization

Intermittent catheterization can often manage overflow incontinence effectively. Residents who have new onset incontinence from a transient, hypotonic/atonic bladder (usually seen following indwelling catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns (e.g., up to approximately 7 days). A voiding trial and post void residual can help identify when bladder tone has returned.

Indwelling Urinary Catheter Use

If the facility provides care for a resident with an indwelling catheter, in collaboration with the medical director and director of nurses, and based upon current professional standards of practice, resident care policies and procedures must be developed and implemented that address catheter care and services, including but not limited to:

- Documentation of the involvement of the resident/representative in the discussion of the risks and benefits of the use of a catheter, removal of the catheter when criteria or indication for use is no longer present, and the right to decline the use of the catheter;*
- Timely and appropriate assessments related to the indication for use of an indwelling catheter;*
- Identification and documentation of clinical indications for the use of a catheter; as well as criteria for the discontinuance of the catheter when the indication for use is no longer present;*
- Insertion, ongoing care and catheter removal protocols that adhere to professional standards of practice and infection prevention and control procedures;*
- Response of the resident during the use of the catheter; and*
- Ongoing monitoring for changes in condition related to potential CAUTI's, recognizing, reporting and addressing such changes.*

*(See **NOTE** below for examples of clinical indications for use.)*

The resident's record must include how and when the resident/representative was involved and informed of care and treatment including the potential use and indications for the need for a catheter, how long use is anticipated, and when and why a catheter must be removed. The resident/representative must be included in the development of the care plan including the use of the catheter and associated interventions. In addition, the resident/representative has the right to decline the treatment. Based on current professional standards of practice, information and education of the resident/representative on the identification of risks and benefits for the use of a catheter must be documented.

Anecdotally, it has been reported that residents or their representatives have requested the use of and/or declined to allow the removal of an indwelling urinary catheter. The record must contain documentation as to why a resident/representative chooses to have or chooses to continue to use a catheter in the absence of clinical indications for use. After determining the reasons, staff and the attending practitioner must document the provision of counseling to assist the resident in understanding the clinical implications and risks associated with the use of a catheter without an

indication for continued use. The care plan must be revised to address the education being provided, including interventions to restore as much urinary function as possible without the use of catheter.

Documentation in the resident's record must reflect the attending practitioner's valid clinical indication to support the use of an indwelling catheter.

NOTE: *The following Table from the CDC, includes examples for appropriate indications for indwelling catheter use and includes both acute and long term care. This table has been adapted to include only those examples relevant for a long term care setting. For the full table and for guidance related to indwelling catheter management and care refer to:*

http://www.cdc.gov/hicpac/cauti/02_cauti2009_abbrev.html

A. Examples of Appropriate Indications for Indwelling Urethral Catheter Use

- *Resident has acute urinary retention or bladder outlet obstruction;*
- *Need for accurate measurements of urinary output;*
- *To assist in healing of open sacral or perineal wounds in incontinent residents;*
- *Resident requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures);and*
- *To improve comfort for end of life care, if needed.*

B. Examples of Inappropriate Uses of Indwelling Catheters

- *As a substitute for nursing care of the resident with incontinence; and*
- *As a means of obtaining urine for culture or other diagnostic tests when the resident can voluntarily void.*

NOTE: *These indications are based on expert consensus.*

Additional care practices related to catheterization include:

- *Recognizing and assessing for complications and their causes, and maintaining a record of any catheter-related problems;*
- *Attempts to remove the catheter as soon as possible when no indications exist for its continuing use;*
- *Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence;*
- *Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter; and*
- *Securing the catheter to facilitate flow of urine, preventing kinking of the tubing and position below the level of the bladder. (Also refer to F880 – Infection Control for policies and procedures related to care of the catheter and equipment, such as tubing, bags, etc.).*

NOTE: *Refer to the CDC site for current information on catheter use, management and care at: http://www.cdc.gov/HAI/ca_uti/uti.html*

Catheter-Related Complications

An indwelling catheter may be associated with significant complications, including bacteremia, febrile episodes, bladder stones, fistula formation, erosion of the urethra, epididymitis, chronic

renal inflammation and pyelonephritis and sepsis related to urinary tract infections. In addition, indwelling catheters are prone to blockage. Risk factors for catheter blockage include alkaline urine, poor urine flow, proteinuria, and preexisting bladder stones.

Some residents with indwelling catheters experience persistent leakage around the catheter. Examples of factors that may contribute to leakage include irritation by a large balloon or by catheter materials, excessive catheter diameter, fecal impaction, and improper catheter positioning. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended.

(Refer to: <https://www.cdc.gov/hicpac/pdf/CAUTI/CAUTIguideline2009final.pdf>)

Catheterization is an important, potentially modifiable, risk factor for UTI. The potential for complications can be reduced by:

- Identifying specific clinical indications for the use of an indwelling catheter;*
- Assessing whether other treatments and services would appropriately address those conditions; and*
- Assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustation, urethral erosion, bladder spasms, hematuria, and leakage around the catheter.*

URINARY TRACT INFECTIONS

Catheter-Related Bacteriuria and UTIs

Bacteriuria (e.g., pyuria) alone in a catheterized individual should not be treated with antibiotics. In someone with nonspecific symptoms such as a change in function or mental status, foul smelling or cloudy urine and/or, bacteriuria (e.g. pyuria), does not necessarily warrant antibiotic treatment. The decision to treat a UTI is based upon the attending practitioner conducting a thorough evaluation and assessment of the resident and providing documentation of a rationale for the indication of use of an antibiotic.

NOTE: *For a non-catheterized resident with symptoms associated with a UTI, the attending practitioner should order a urine culture prior to the initiation of antibiotic therapy to help guide treatment. According to current standard of practice, an accurate urine culture for a non-catheterized resident should be obtained by a clean catch or mid-stream specimen for residents who are able to follow instructions. For those unable to provide a clean-catch, a specimen may be obtained preferably by a freshly placed condom catheter for males, or in and out catheterization for females or males unable to provide a specimen by a condom catheter. If the resident has a long-term indwelling urethral catheter, a specimen should be obtained from a freshly placed indwelling catheter. Reference - the IDSA Guidelines for Evaluation of Fever and Infection in Older Adult Residents of Long-Term Care Facilities. (High et al. Clinical Infectious Diseases, 2009:48-149-71).*

The surveyor should determine if facility policy for obtaining urine for cultures is based upon current standards of practice, understanding that these standards may be revised and updated over time. The facility should be able to provide the most current standard that supports the policy that they have developed and implemented. (Also refer to F880 Infection Control and F881 for antibiotic stewardship program for infection assessment tools.)

Unnecessary treatment of a UTI with antibiotics may lead to the development of multi drug resistant organisms (e.g., Methicillin-Resistant Staphylococcus Aureus) and other complications such as the development of clostridium-difficile infection, which may predispose the person to prolonged treatment potential hospitalization and may pose a threat of infection to other residents. (Also refer to F881 for antibiotic stewardship program for infection assessment tools.)

NOTE: *Standards of practice may be revised and updated over time.*

One current professional standard of practice that addresses criteria for use of antibiotics for UTI's, includes:

“Minimum criteria for initiating antibiotics for an indication of urinary tract infection were considered for residents with no indwelling urinary catheters and for residents with chronic indwelling catheters.

- 1. For residents who do not have an indwelling catheter, minimum criteria for initiating antibiotics include: >10⁵ CFU/mL (positive) or pending urine culture and dysuria alone or two or more of the following: fever (>37.9°C [100°F] or 1.5°C [2.4°F] increase above baseline temperature on two occasions over last 12 hours), new or worsening urgency, frequency, suprapubic pain, gross hematuria, costovertebral angle tenderness (flank pain), urinary incontinence, or shaking chills.*
- 2. For residents who have an indwelling catheter or a suprapubic catheter), minimum criteria for initiating antibiotics include the presence of: >10⁵ CFU/mL (positive) or pending urine culture and one or more of the following: fever (>37.9°C [100°F] or 1.5°C [2.4°F] increase above baseline temperature on two occasions over last 12 hours), new costovertebral tenderness, rigors (shaking chills), or new onset of delirium.”*

NOTE: *Reference - Loeb M, Brazil K, Lohfeld L, et al. Effect of a multifaceted intervention on number of antimicrobial prescriptions for suspected urinary tract infections in residents of nursing homes: cluster randomised controlled trial. BMJ. 2005;331:669. [[PMC free article](#)] [[PubMed](#)]*

Follow-Up of UTIs

The goal of treating a UTI is to alleviate systemic or local symptoms, not to eradicate all bacteria. Therefore, a post-treatment urine culture is not necessary but may be useful if UTI signs and symptoms continue or do not respond to antibiotic treatment. Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy. Recurrent UTIs (2 or more in 6 months) in a noncatheterized individual may warrant additional evaluation (such as a determination of an abnormal post void residual (PVR) urine volume or a referral to a urologist) to rule out structural abnormalities such as enlarged prostate, prolapsed bladder, periurethral abscess, strictures, bladder calculi, polyps and tumors.

Recurrent UTIs in a catheterized individual should lead the facility to look for possible impairment of free urine flow through the catheter, to re-evaluate the techniques being used for catheter care and for perineal hygiene including the removal of fecal soiling, and to reconsider the relative risks and benefits of continuing the use of an indwelling catheter.

Because the major factors (other than an indwelling catheter) that predispose individuals to bacteriuria, including physiological aging changes and chronic comorbid illnesses, cannot be modified readily, the facility should demonstrate that they:

- *Employ infection prevention and control practices (e.g. Standard Precautions) in managing catheters and associated drainage system;*
- *Keep the resident and catheter clean of feces to minimize bacterial migration into the urethra and bladder (e.g., cleaning fecal material away from, rather than towards, the urinary meatus), however, routine perineal care with an antiseptic is not recommended;*
- *Maintain free urine flow through any indwelling catheter; and*
- *Assess for fluid needs and implement a fluid management program (using alternative approaches as needed) based on those assessed needs.*

FECAL INCONTINENCE

Fecal incontinence (FI) involves the unintentional loss of solid or liquid stool. A resident experiencing FI may experience feelings of shame, embarrassment, loss of independence, may tend to isolate himself/herself creating a decrease in social interactions/activities due to fear of “accidents” with associated odors, leakage and soiling of clothing or furnishings. It is important for the facility and the attending practitioner to complete a comprehensive assessment and determine, with the resident/representative, potential treatment and care plan interventions, and to provide ongoing evaluation of the response to those interventions. The resident should be re-evaluated whenever there is a change in bowel function. If the resident has FI that has already been investigated, documented, and determined to be irreversible or not significantly improvable, additional studies may be of limited value, unless there has been advancement in available treatments.

Risk factors for Fecal Incontinence

Risk factors for FI may include, aging and dependency in daily activities, smoking and pulmonary disease, arthritis in adults over 75 years of age, older adults with rectal cancer, comorbidities such as kidney disease, transient ischemic attacks in men, women with arterial hypertension, acute stroke (FI may depend on the severity of a stroke), functional dependency and need for assistance with toilet access 3 months after stroke in men and women, and poor general health and dementia.

<http://archive.ahrq.gov/downloads/pub/evidence/pdf/fuiad/fuiad.pdf>

Assessment:

To ensure that a resident who is incontinent of bowel receives appropriate treatment and services, the facility must conduct an assessment to identify the presenting symptoms and type of FI, including the potential reversible/irreversible causes and risks. Symptoms or types of FI may include (as noted in <http://s3.gi.org/physicians/guidelines/FecalIncontinence.pdf>):

- ***“Passive incontinence*** —*which is the involuntary discharge of fecal matter or flatus without any awareness. This suggests a loss of perception and/or impaired rectoanal reflexes either with or without sphincter dysfunction;*
- ***Urge incontinence*** — *which is the discharge of fecal matter or flatus in spite of active attempts to retain these contents. Here, there is a predominant disruption of the sphincter function or the rectal capacity to retain stool; and/or*

- **Fecal seepage** — which is the undesired leakage of stool, often after a bowel movement with otherwise normal continence and evacuation. This condition is mostly due to incomplete evacuation of stool and/or impaired rectal sensation. The sphincter function and pudendal nerve function are mostly intact”.

Causes and Treatment of Fecal Incontinence

For reference, the following potential causes and treatments of FI have been adapted from the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) to address the long term care setting. For the full description of causes and treatment for FI, refer to: <http://www.niddk.nih.gov/health-information/health-topics/digestive-diseases/fecal-incontinence/Pages/facts.aspx>

Potential causes for FI may include:

- Diarrhea;
- Constipation Muscle Damage or Weakness;
- Trauma, childbirth injuries, cancer surgery, and hemorrhoid surgery;
- Nerve Damage;
- Loss of Stretch in the Rectum;
- Childbirth by Vaginal Delivery;
- Hemorrhoids and Rectal Prolapse;
- Rectocele and;
- Inactivity

Potential treatment/interventions for FI should be based upon the type of FI. Potential treatment options and interventions may include:

- Eating increased amounts of fiber;
- Drinking sufficient liquids;
- Use of medications to develop more solid stools that are easier to control;
- Pelvic Floor Exercises and Biofeedback that strengthen the pelvic floor muscles may improve bowel control. Success with pelvic floor exercises depends on the cause of fecal incontinence, its severity, and the person’s motivation and ability to follow the health care provider’s recommendations;
- Surgery may be an option for fecal incontinence that fails to improve with other treatments or for fecal incontinence caused by pelvic floor or anal sphincter muscle injuries;
- Electrical Stimulation also called sacral nerve stimulation or neuromodulation, involves placing electrodes in the sacral nerves to the anus and rectum and continuously stimulating the nerves with electrical pulses.

Care Plan

For the resident with fecal incontinence, the care plan must reflect the results of the resident’s assessment and include resident specific interventions for any potential reversible causes and, if irreversible, appropriate interventions for management of fecal incontinence. Interventions and the provision of care should address treating the resident with respect, enhancing dignity and self-worth and reducing embarrassment and shame in relation to FI. Based upon the increased

risk for transmission of infection resulting from fecal contamination, the care plan should also identify the PPE appropriate for use during the delivery of care.

Complications Potentially Related to Fecal Incontinence

Complications related to fecal incontinence may include, but are not limited to, emotional distress, loss of self-esteem, social isolation, physical complications such as skin irritation/excoriation, itching, pain, and in addition, frequent loose stool may be an indicator of fecal impaction.

KEY ELEMENTS OF NONCOMPLIANCE

To cite deficient practice at F690, the surveyor's investigation will generally show that the facility failed to do one or more of the following:

- *Provide appropriate and sufficient services and assistance to:*
 - *Maintain bladder continence and/or bowel function in continent residents; or*
 - *Restore bladder continence and/or bowel function as possible, based on a comprehensive assessment and clinical condition; or*
 - *Prevent urinary tract infections to the extent possible;*
- *Ensure that a resident is not catheterized unless required by his/her clinical condition; or*
- *Ensure that a urinary catheter is removed as soon as possible unless the catheter is necessary because of the residents' clinical condition.*

INVESTIGATIVE PROTOCOL

Use

Use the Bladder and Bowel Incontinence Critical Element (CE) Pathway, and/or Urinary Catheter and UTI CE Pathway, for the condition being evaluated, along with the above interpretive guidelines when determining if the facility provides the necessary care and services to meet the resident's needs.

Summary of Procedure

Briefly review the most recent comprehensive assessments, comprehensive care plan and orders to identify whether the facility has assessed and developed an individualized care plan based on professional standards of practice and provided by qualified, competent staff. During this review, identify the extent to which the facility has implemented interventions in accordance with the resident's needs, goals for care and professional standards of practice, consistently across all shifts. This information will guide observations and interviews to be made in order to corroborate concerns identified.

NOTE: *Always observe for visual cues of psychosocial distress and harm (see Appendix P, Guidance on Severity and Scope Levels and Psychosocial Outcome Severity Guide).*

DEFICIENCY CATEGORIZATION

In addition to actual or potential physical harm, always consider whether psychosocial harm has occurred when determining severity level (See Appendix P, Section IV, E, Psychosocial Outcome Severity Guide).

An example of Severity Level 4 Noncompliance Immediate Jeopardy to Resident Health or Safety includes but is not limited to:

- *The facility failed to ensure that a resident who entered the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible, resulting in the resident continuing to have the catheter in place for three weeks and developing a urinary tract infection, leading to sepsis. The facility failed to provide appropriate treatment and services for a resident with fecal incontinence, resulting in the resident having severely excoriated and ulcerated areas of skin around the rectal area, with odor, and purulent exudate. The resident expressed severe pain and refused to leave her room.*

Examples of Severity Level 3 Noncompliance Actual Harm that is not Immediate Jeopardy includes but is not limited to:

- *The facility failed to assure that a resident who entered the facility with an indwelling catheter was assessed for removal of the catheter as soon as possible, unless the resident's clinical condition demonstrates that catheterization is necessary. During the survey, a resident was identified as having an indwelling urinary catheter in place for several months. The resident was currently being treated with an antibiotic for a symptomatic urinary tract infection. Staff interviewed were unable to provide the clinical indication for use for the catheter, and the record did not contain documentation for the initial use of the catheter or for the continued use of a urinary catheter. The resident was unable to be interviewed, but his representative was interviewed but did not know why the catheter was in place, except that the resident had a problem with incontinence. Record review indicated that the resident had experienced repeated complications such as recurrent symptomatic UTIs which required treatment with antibiotics.*
- *The facility failed to assure that a resident who was incontinent of bladder received the appropriate treatment and services to restore continence to the extent possible. A resident was identified as incontinent of bladder. Based upon the resident's assessment and identification of the type of urinary incontinence, the facility developed interventions for a restorative program to restore continence. However, based on observations, staff were not implementing the interventions on the care plan, did not respond to the resident's request for assistance with use of the bathroom, and were not monitoring the progress of the interventions. The resident stated that she was frustrated and embarrassed regarding the odors and wetness that occurred as a result of the incontinence episodes. She also stated that she did not attend activities or go for meals as she needed close access to the toilet, and that she didn't want to be around others when she had incontinent episodes. She stated that she felt that she was not improving with her bladder continence, and that it was worse now than when she started the restorative program. Staff interviewed stated that they were aware of the program, but they were not able to implement the program, consistently on all shifts, as they had other resident's and duties assigned during their shifts and were unable to respond. The record reflected a decline in continence since the program began. (Also cited at sufficient staffing at F726)*

Examples of Severity Level 2 Considerations: No Actual Harm with Potential for More Than Minimal Harm that is Not Immediate Jeopardy include but are not limited to:

- *The facility failed to provide appropriate treatment and services for care of a resident with a clinically-justified indwelling catheter. During observations of care for a resident with an indwelling catheter, urine was noted to be leaking. Staff interviewed stated that they were not sure why the catheter leaked, but that they kept the resident as dry as possible. In addition, it was observed several times throughout the survey, that the catheter drainage bag and tubing were placed directly on the floor in the resident's room. There were no indications of skin maceration and/or irritation, or symptoms of a UTI symptoms.*
- *The facility failed to provide appropriate treatment and services for care of a resident who had intermittent fecal incontinence. During the survey, a resident was observed to stay in her room, did not attend activities and had meals served in her room. The resident was identified as alert and aware of her care needs. She stated that she had problems with intermittent fecal incontinence and was on a bowel management program that included extra fiber and liquids. She stated that recently there were changes in meal service and she was not receiving the extra fiber. She also stated that staff were to assist her with hygiene when incontinence episodes occurred, but they had not consistently provided the care. She stated that when she had the fecal incontinence episodes, she did not attend activities she enjoyed attending, and was irritated that she was unable to attend due to not receiving hygiene when needed.*

Severity Level 1: No actual harm with potential for minimal harm

The failures of the facility to provide appropriate care and services to maintain or improve continence, manage indwelling catheters, and minimize negative outcome places residents at risk for more than minimal harm. Therefore, Severity Level 1 does not apply for this regulatory requirement.

Resources

Research into appropriate practices to prevent, manage, and treat urinary incontinence, urinary catheterization, and UTI continues to evolve. Many recognized clinical resources on the prevention and management of urinary incontinence, infection, and urinary catheterization exist. Some of these resources include:

- *The American Medical Directors Association (AMDA) - Clinical Practice Guidelines: Clinical Practice Guidelines, 1996 - <http://www.amda.com/tools/guidelines.cfm>*
- *<http://www.mc.vanderbilt.edu/documents/cqa/files/Incontinence%20Management/Vanderbilt%20Incontinence%20Management%20Module.pdf>*
- *Association for Professionals in Infection Control and Epidemiology (APIC) at www.apic.org:*
- *Centers for Disease Control at www.cdc.gov;*
- *The Annals of Long Term Care publications: <http://www.annalsoflongtermcare.com/search?keywords=urinary%20catheters>*
- *Urology Care Foundation – The Official Foundation of the American Urological Association - <http://www.urologyhealth.org/>*
- *The American Geriatrics Society at www.americangeriatrics.org*
- *<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/>*

Surveillance Definitions of Infections in Long-Term Care Facilities: Revisiting the McGeer Criteria

Resources for Fecal Incontinence:

- *https://www.fascrs.org/sites/default/files/downloads/publication/clinical_practice_guideline_for_the_treatment_of_fecal_incontinence.pdf*
- *<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2614622/>*

F691

Quality of Care

§483.25(f)

Colostomy, Urostomy, or Ileostomy Care

Survey Regulations & Interpretive Guidelines

F691

(Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.25(f) Colostomy, urostomy, or ileostomy care.

The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

INTENT §483.25(f)

The intent of this provision is that the resident receives the necessary care and treatment including medical and nursing care and services when they need colostomy, urostomy, or ileostomy care.

PROCEDURES AND PROBES §483.25(f)

Refer to appropriate sections of the MDS, as applicable.

Identify if the resident triggers any Care Area Assessments for urinary incontinence, nutritional status, and/or pressure injuries (skin care).

- If appropriate, is the resident provided with self-care instructions?*
- Does the staff member observe and respond to any signs of the resident's discomfort about the ostomy or its care?*
- Is skin surrounding the ostomy free of excoriation (abrasion, breakdown)?*
- If excoriation is present, does the clinical record indicate an onset and a plan to treat the excoriation?*

SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.

H0100: Appliances

H0100. Appliances	
↓ Check all that apply	
<input type="checkbox"/>	A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)
<input type="checkbox"/>	B. External catheter
<input type="checkbox"/>	C. Ostomy (including urostomy, ileostomy, and colostomy)
<input type="checkbox"/>	D. Intermittent catheterization
<input type="checkbox"/>	Z. None of the above

Item Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote resident dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.

Planning for Care

- Care planning should include interventions that are consistent with the resident's goals and minimize complications associated with appliance use.

DEFINITIONS

INDWELLING CATHETER

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

SUPRAPUBIC CATHETER

An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

NEPHROSTOMY TUBE

A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

- Examine the resident to note the presence of any urinary or bowel appliances.
- Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. Select **none of the above** if none of the appliances A-D were used in the past 7 days.*

- H0100A**, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B**, external catheter
- H0100C**, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D**, intermittent catheterization
- H0100Z**, none of the above

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters (males) and external urinary pouches (females) are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterization for urine specimen during look-back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER

Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

OSTOMY

Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY

A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

ILEOSTOMY

A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

COLOSTOMY

A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

INTERMITTENT CATHETERIZATION

Insertion and removal of a catheter through the urethra for bladder drainage.

H0100: Appliances (cont.)

- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

H0200: Urinary Toileting Program

H0200. Urinary Toileting Program	
Enter Code <input type="checkbox"/>	<p>A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility?</p> <p>0. No → Skip to H0300, Urinary Continence 1. Yes → Continue to H0200B, Response 9. Unable to determine → Skip to H0200C, Current toileting program or trial</p>
Enter Code <input type="checkbox"/>	<p>B. Response - What was the resident's response to the trial program?</p> <p>0. No improvement 1. Decreased wetness 2. Completely dry (continent) 9. Unable to determine or trial in progress</p>
Enter Code <input type="checkbox"/>	<p>C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?</p> <p>0. No 1. Yes</p>

Item Rationale

Health-related Quality of Life

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
 - determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
 - completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
 - implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.

H0200: Urinary Toileting Program (cont.)

- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence and changing his or her brief if needed and providing good skin care).

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

DEFINITIONS

BLADDER

REHABILITATION/

BLADDER RETRAINING

A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

PROMPTED VOIDING

Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet.

HABIT TRAINING/ SCHEDULED VOIDING

A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE

Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
 - implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern;
 - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
 - notations of the resident's response to the toileting program and subsequent evaluations, as needed.
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- **Code 0, no:** if for any reason the resident did not undergo a toileting trial. This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial. Skip to **Urinary Continence** item (H0300).
- **Code 1, yes:** for residents who underwent a trial of an individualized, resident-centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
- **Code 9, unable to determine:** if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- **Code 0, no improvement:** if the frequency of resident's urinary incontinence did not decrease during the toileting trial.
- **Code 1, decreased wetness:** if the resident's urinary incontinence frequency decreased, but the resident remained incontinent. There is no quantitative definition of improvement. However, the improvement should be clinically meaningful—for example, having at least one less incontinent void per day than before the toileting program was implemented.

H0200: Urinary Toileting Program (cont.)

- **Code 2, completely dry (continent):** if the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial. (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)
- **Code 9, unable to determine or trial in progress:** if the response to the toileting trial cannot be determined because information cannot be found or because the trial is still in progress.

Coding Instructions H0200C, Current Toileting Program

- **Code 0, no:** if an individualized resident-centered toileting program (i.e., prompted voiding, scheduled toileting, or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence.
- **Code 1, yes:** for residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding). Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code "yes."

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
 - simply tracking continence status,
 - changing pads or wet garments, and
 - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
 - H0200A would be **coded 1, yes,**
 - H0200B would be **coded 9, unable to determine or trial in progress,** and
 - H0200C would be **coded 1, yes.**

H0200: Urinary Toileting Program (cont.)

Examples

1. Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding assessment/diary indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb her sleep.

Coding: H0200A would be **coded as 0, no**. H0200B and H0200C would be skipped.

Rationale: Based on this resident's voiding assessment/diary, there was no pattern to her incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no, skip to H0300, Urinary Continence.

2. Mr. M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving his 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

Coding: H0200A would be **coded as 1, yes**.

H0200B would be **coded as 9, unable to determine or trial in progress**.

H0200C would be **coded as 1, current toileting program or trial**.

Rationale: Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as 1, yes. Based on the assessment it was determined that incontinence episodes could be reduced, therefore H0200B is coded as 9, unable to determine or trial in progress. An individualized plan has been developed, implemented, and communicated to the resident and staff, therefore H0200C is coded as 1, current toileting program or trial.

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code <input type="checkbox"/>	Urinary continence - Select the one category that best describes the resident 0. Always continent 1. Occasionally incontinent (less than 7 episodes of incontinence) 2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding) 3. Always incontinent (no episodes of continent voiding) 9. Not rated , resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
 - interfere with participation in activities,
 - be socially embarrassing and lead to increased feelings of dependency,
 - increase risk of long-term institutionalization,
 - increase risk of skin rashes and breakdown,
 - increase risk of repeated urinary tract infections, and
 - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE

The involuntary loss of urine.

CONTINENCE

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

Planning for Care

- For many residents, incontinence can be resolved or minimized by
 - identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
 - eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
 - bladder retraining, prompted voiding, or scheduled toileting.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
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.

H0300: Urinary Continence (cont.)

Coding Instructions

- **Code 0, always continent:** if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence.
- **Code 1, occasionally incontinent:** if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.
- **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.
- **Code 3, always incontinent:** if during the 7-day look-back period, the resident had no continent voids.
- **Code 9, not rated:** if during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g., is on chronic dialysis with no urine output) for the entire 7 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

Examples

1. An 86-year-old female resident has had longstanding stress-type incontinence for many years. When she has an upper respiratory infection and is coughing, she involuntarily loses urine. However, during the current 7-day look-back period, the resident has been free of respiratory symptoms and has not had an episode of incontinence.

Coding: H0300 would be **coded 0, always continent**.

Rationale: Even though the resident has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

2. A resident with multi-infarct dementia is incontinent of urine on three occasions on day one of observation, continent of urine in response to toileting on days two and three, and has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

Coding: H0300 would be **coded as 2, frequently incontinent**.

Rationale: The resident had seven documented episodes of urinary incontinence over the look-back period. The criterion for “frequent” incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

H0300: Urinary Continence (cont.)

3. A resident with Parkinson’s disease is severely immobile and cannot be transferred to a toilet. He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed. He did not have a continent void during the 7-day look-back period.

Coding: H0300 would be **coded as 3, always incontinent.**

Rationale: The resident has no urinary continent episodes and cannot be toileted due to severe disability or discomfort. Incontinence is managed by a check and change in protocol.

4. A resident had one continent urinary void during the 7-day look-back period, after the nursing assistant assisted him to the toilet and helped with clothing. All other voids were incontinent.

Coding: H0300 would be **coded as 2, frequently incontinent.**

Rationale: The resident had at least one continent void during the look-back period. The reason for the continence does not enter into the coding decision.

H0400: Bowel Continence

Note: There are images imbedded in this manual and if you are using a screen reader to access the content contained in the manual you should refer to the data item set to review the referenced information.

H0400. Bowel Continence	
Enter Code <input type="checkbox"/>	Bowel continence - Select the one category that best describes the resident 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 9. Not rated , resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- Incontinence can
 - interfere with participation in activities,
 - be socially embarrassing and lead to increased feelings of dependency,
 - increase risk of long-term institutionalization,
 - increase risk of skin rashes and breakdown, and
 - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
 - identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
 - eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

H0400: Bowel Continence (cont.)

- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if he or she is capable of reliably reporting his or her bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions

- **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.
- **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 9, not rated:** if during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days. (Note that these residents should be checked for fecal impaction and evaluated for constipation.)

Coding Tips and Special Populations

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

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code <input type="checkbox"/>	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences of incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skin care).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
 - implementation of an individualized, resident-specific bowel toileting program based on an assessment of the resident's unique bowel pattern;
 - evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, verbal and a written report; and
 - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

H0500: Bowel Toileting Program (cont.)

Coding Instructions

- **Code 0, no:** if the resident is not currently on a toileting program targeted specifically at managing bowel continence.
- **Code 1, yes:** if the resident is currently on a toileting program targeted specifically at managing bowel continence.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code	Constipation present?
<input type="checkbox"/>	0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
 - dehydration due to a medical condition or inadequate access to and intake of fluid, and
 - side effects of medications.

DEFINITION

CONSTIPATION

If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period.
2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. Speak with family members or significant others if the resident is unable to report on bowel habits.
3. Ask direct care staff who routinely work with the resident on all shifts about problems with constipation.

DEFINITION

FECAL IMPACTION

A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

H0600: Bowel Patterns (cont.)

Coding Instructions

- **Code 0, no:** if the resident shows no signs of constipation during the 7-day look-back period.
- **Code 1, yes:** if the resident shows signs of constipation during the 7-day look-back period.

Coding Tips and Special Populations

- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

CDC GUIDELINES FOR INDWELLING URINARY CATHETER

Updated Recommendations for long-term indwelling urinary catheter from CDC, Catheter Associated Urinary Tract Infections (CAUTI) information:

1. Change indwelling urinary catheter prn for
 - a. Encrustation
 - b. Leakage
 - c. Bleeding
 - d. When there is an order to obtain specimen for UA/C&S
2. Utilize closed system for catheter insertion to decrease risk of introducing bacteria into the bladder
3. DO NOT recommend routine changes (eg. Q 30 days)
4. DO NOT recommend changing the urinary drainage bag
5. If the urinary system is compromised it is recommended that the whole system be changed

NOTE: It is recommended that a process be implemented for having the license nurse check the catheter at regular intervals, especially for encrustation.

POLICY/PROCEDURE

SUBJECT: Incontinence

DATE:

INTENT:

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

PROCEDURE:

1. For a continent resident, the facility will ensure that based on the resident's comprehensive assessment that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.
2. For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that:
 - a. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
 - b. A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
 - c. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.
3. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

PROCEDURE

SUBJECT: Indwelling Catheter Justification and Removal

DATE:

POLICY:

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

PROCEDURE:

1. When a resident is admitted with an indwelling catheter, the admitting nurse will complete the NSG - Indwelling Urinary Catheter Justification evaluation.
2. The admitting nurse will document the indwelling catheter size and obtain an order from the physician or physician extender to change the catheter as needed for blockage, as well as obtain a supporting diagnosis for use of the catheter.
3. The admitting nurse will also obtain orders to perform catheter care on each shift, to irrigate the catheter as needed for occlusion or blockage, and may change indwelling urinary catheter to obtain urine culture.
4. When there is no supporting diagnosis for the use of the indwelling urinary catheter, the admitting nurse will obtain an order from the physician or physician extender to remove, along with orders for notification when the resident does not void.
5. The continued use of the indwelling urinary catheter will be evaluated in conjunction with the RAI process.
6. Once the indwelling urinary catheter has been removed the nurse removing the catheter will document this in the electronic medical record and initiate the 5-day tracking and trending in Point of Care for the nursing assistant to document voiding.
7. Update the care plan as indicated based on outcome.

POLICY/PROCEDURE

SUBJECT: Indwelling Urinary Catheter Use

DATE:

INTENT:

It is the policy of the facility to ensure the appropriate use of indwelling urinary catheters in accordance with State and Federal Regulations, and national guidelines.

PROCEDURE:

1. Indwelling urinary catheters are to be used when indicated according to national guidelines such as those by the Healthcare Infection Control Practices Advisory Committee (HICPAC) Guidelines (often referred to as the Centers for Disease Control and Prevention guidelines). Exceptions may be made on a case-by-case basis upon evaluation by infection prevention and control coordinator, director of nursing, and ordering physician.
2. Indications for using indwelling urinary catheters per HICPAC guidelines include:
 - a. Resident has acute urinary retention or bladder outlet obstruction;
 - b. Need for accurate measurements of urinary output in critically ill residents;
 - c. Perioperative use for selected medical procedures;
 - d. To assist in healing of open sacral or perineal wounds in incontinent residents;
 - e. Resident requires prolonged immobilization; and
 - f. To improve comfort for end of life care.
3. Urinary catheters are not to be used to manage incontinence.
4. Urinary catheters are to be discontinued when resident no longer meets indication for use. Resident's indication for use of an indwelling urinary catheter is reviewed regularly by nursing staff.
5. Indwelling urinary catheters and drainage bags should not be changed at routine or fixed intervals. Indwelling urinary catheters and drainage bags are changed when there is indication of infection, obstruction, or as clinically indicated.
6. An indwelling urinary catheter should be changed prior to collecting a urine specimen for laboratory testing.

PROCEDURE

SUBJECT: Indwelling Catheter Care

DATE:

INTENT:

It is the policy of the facility to ensure that the residents receive care and services to prevent urinary tract infections in those residents with an indwelling catheter, in accordance with standards of practice.

PROCEDURE:

1. Perform hand hygiene before beginning the procedure and assemble all supplies.
2. Knock before entering room, introduce self and explain procedure to the resident.
3. Place supplies on the bedside stand or over-bed table and arrange supplies so that they can be easily reached. Pull the cubicle curtain around the bed for privacy.
4. Perform hand hygiene and put on gloves.
5. Position resident for comfort.
6. Using disposable wipes cleanse: female labia with single downward, cleansing stroke using a different side of the wipe for each cleansing stroke for each side of the labia and the urethral meatus; male glans with circular strokes from the meatus outward, using a different side of wipe for each cleansing circular stroke as needed. For uncircumcised males, retract the foreskin cleanse the meatus as described and return foreskin to normal position.
7. Secure catheter tubing with non-dominant hand and with a single downward, cleansing stroke cleanse catheter tubing from meatus towards collection bag.
8. Turn resident on side to perform backside cleansing again using single cleansing strokes from front to back and reposition resident for comfort.
9. Discard supplies, remove gloves and wash hands.

PROCEDURE

SUBJECT: Bowel and Bladder Program

DATE:

INTENT:

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling urinary catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with State and Federal Regulations.

PROCEDURE:

1. All residents admitted to facility will have a Bowel and Bladder Continence Evaluation performed at the time of admission, in conjunction with each quarterly and annual assessment, with any significant change assessment and as deemed necessary by the Interdisciplinary Team; this includes the removal of an indwelling urinary catheter.
2. The admitting nurse or designee is responsible for completing the initial evaluation.
3. The admitting nurse or designee will then be responsible for initiating the 5-Day Resident Tracking/Trending Bowel and Bladder Pattern in the electronic medical record for all new admissions.
4. The C.N.A. responsible for the resident at the time of admission will begin the tracking and trending within the electronic medical record.
5. After the 5 days the DON or designee will review the documentation looking for an established pattern.
6. The DON or designee along with the Interdisciplinary Team will evaluate the appropriate program for the resident and refer to Restorative if appropriate.
7. When appropriate, the DON or designee will initiate the Restorative Bowel and/or Bladder Retraining Program. This is a 14-day program.
8. The DON or designee will assign tasks within the electronic medical record for toileting times identified during the 5-day tracking/trending of incontinence; this will alert the C.N.A. to toilet one hour prior to attempt retraining.
9. After 14 days the Unit Manager or designee will reevaluate the appropriateness to continue with current plan or change the current plan.

PROCEDURE

SUBJECT: External Catheter Care

DATE:

INTENT:

It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling urinary catheter, unless clinically necessary and promotes urinary continence of its residents, in accordance with each resident's rights, State and Federal Regulations.

DEFINITION:

EXTERNAL CATHETER: A Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

PROCEDURE:

1. Verify physician order for external catheter and gather supplies.
2. Enter resident's room by knocking, identify resident and explain procedure.
3. Set up supplies on barrier.
4. Perform hand hygiene and don gloves.
5. If there is an external catheter in place, remove appliance and discard.
6. Remove gloves, perform hand hygiene and apply clean gloves.
7. Cleanse the penis of the male patient and the labia of the female patient and pat dry.
8. Inspect the skin to make sure it does not have any broken or reddened area(s).

For the male patient:

9. Gently roll the condom over the penis. Leave 1 to 2 inches of the condom catheter at the end of the penis.
10. Wrap the sheath holder around the condom at the base of the penis. Do not wrap the sheath holder too tightly because this may stop blood flow to the penis.
11. Connect the condom catheter to the urinary collection bag.
12. Secure the tubing of collection bag.
13. Remove gloves and perform hand hygiene.
14. Remove trash from room.
15. Document procedure and findings.

For the female patient:

16. Gently apply receptacle pouch to the patient's labia.
17. Connect the condom catheter to the urinary collection bag.
18. Secure the tubing of collection bag.
19. Remove gloves and perform hand hygiene.
20. Remove trash from room.
21. Document procedure and findings.

POLICY/PROCEDURE

SUBJECT: Colostomy, Urostomy, or Ileostomy Care

DATE:

INTENT:

It is the policy of the facility to provide Colostomy, Urostomy, or Ileostomy Care Services in accordance to State and Federal regulations.

PROCEDURE:

The facility will ensure that a resident who requires colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

BOWEL AND BLADDER CONTINENCE EVALUATION

(This may also be used to meet the intent of CAA 6)

Resident Name: _____

Room: _____

Conditions	0	1	2	3	Score			
Cognitive Status	No LIMITATIONS Alert, orientated x4(person, place, time & situation) decisions consistent and reasonable	SLIGHTLY IMPAIRED Occasional confusion; difficulty in some new situations only	MODERATELY IMPAIRED Frequently confused and disoriented; decisions poor; requires cues and supervision	SEVERELY IMPAIRED Continual confusion; decisions never or rarely made/also include comatose resident				
Medical Diagnosis Number of the following diagnosis: ASHD, CHF, HTN, Pacemaker, CVA, TIA, MS, Amputation, Asthma, Delirium, UTI, AtrophicVaginitis, DM Hemi/Para/Quadriplegia, OA Hx fractures, Pain, COPD, Dementia, Psychosis, Depression, Anxiety, Vit B12 def., Cancer, Parkinson's Dx Hypo/ hyperthyroidism, Spinal Cord or Brain Lesions, Tabes dorsalis, Neurogenic Bladder,BPH	NONE	One	Two	Three or more				
Mobility	INDEPENDENT Fully ambulatory; self-sufficiency once in w/c; able to transfer to and from toilet	LIMITED ASSISTANCE Ambulates w/ device (walker, cane) transfers to/from toilet w/min. assistance	EXTENSIVE ASSISTANCE Ambulates and Transfers to and from toilet with moderate assistance	DEPENDENT Non weight bearing; unable to transfer without full staff support				
Urinary Continence	ALWAYS CONTINENT	OCCASIONALLY INCONTINENT Incontinent< 7 episode of incontinence per week	FREQUENTLY INCONTINENT Incontinent >7 episodes of incontinence, w/at least 1 episode of continent voiding	ALWAYS INCONTINENT No episodes of continent voiding				
Not Rated - Urinary	Resident has a catheter (Indwelling, condom), Urinary Ostomy or no output for the entire 7 days. (Not Rated always equals a score of 3)							
Type Of Incontinence	<input type="checkbox"/> Stress (occurs with coughing, sneezing, laughing, lifting heavy objects, etc.), <input type="checkbox"/> Urge (Overactive or spastic bladder), <input type="checkbox"/> Mixed (stress incontinence with urgency), <input type="checkbox"/> Overflow (due to blocked urethra or weak bladder muscles) <input type="checkbox"/> Transient (temporary / occasional related to a potentially improvable/ reversible cause), Functional (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating) (1 or more equals a score of 3)							
Bowel Continence	ALWAYS CONTINENT	OCCASIONALLY INCONTINENT One episode of bowel incontinence	FREQUENTLY INCONTINENT 2 or more episodes of bowel incont., but at least one continent bowel movement	ALWAYS INCONTINENT No episodes of continent bowel movements				
Not Rated – Bowel	Resident had an ostomy or did not have a bowel movement for the entire 7 days. (Not rated always equals a score of 3)							

BOWEL AND BLADDER CONTINENCE EVALUATION

(This may also be used to meet the intent of CAA 6)

Conditions	0	1	2	3	Score			
Bowel Patterns	Constipation present? <input type="checkbox"/> Yes or <input type="checkbox"/> No (If Yes score equals 3, if No score equals 0) Constipation Definitions – If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult to pass no matter what the frequency of bowel movements.							
Fecal Impaction	Fecal Impaction present? <input type="checkbox"/> Yes or <input type="checkbox"/> No (If Yes score equals 3, if No score equals 0). A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.							
Medications Number of the following medications: Diuretics, Sedative hypnotics, Anticholinergic, Narcotics, Calcium Channel blockers,	NONE	1	2	3 or more				
Laboratory Tests High serum calcium, High Blood Glucose, Low B12, High BUN or Creatinine	NONE	One or more equals a 3.						
Other	<input type="checkbox"/> Caffeine use, <input type="checkbox"/> Physician Diagnosed Excessive Fluid Intake and or Excessive Urine Output and or Inadequate Urine Output, <input type="checkbox"/> Restricted Mobility, <input type="checkbox"/> Lack of Toilet Access, <input type="checkbox"/> Use of Pads or Briefs, <input type="checkbox"/> Restraints, <input type="checkbox"/> Dx of Coma, <input type="checkbox"/> Terminal Illness, <input type="checkbox"/> Stage 3 or 4 in an area affected by incontinence, <input type="checkbox"/> Medical Need for urine output measurement, or <input type="checkbox"/> Hx of inability to void after catheter removal (1 or more equals score of 3)							
TOTALS					Enter Totals			
<p>0 – 9 = High restorative potential (Retraining Program to be attempted)</p> <p>10 – 15 = Moderate restorative potential (Retraining Program attempted or Prompted) Date: _____</p> <p>16 – 21 = Low restorative potential (Retraining Program Unlikely/Prompted/Scheduled Plan) Initial: _____</p> <p>>22 = Minimal restorative potential (Check and Change Plan)</p>								
_____ Initial Signature/Date Of Above Evaluation				_____ Initial Signature/Date Of Above Evaluation				
_____ Initial Signature/Date Of Above Evaluation				_____ Initial Signature/Date Of Above Evaluation				
Input from resident and/or family/representative regarding continence: _____								

BOWEL AND BLADDER CONTINENCE EVALUATION

(This may also be used to meet the intent of CAA 6)

Analysis and Findings	Care Plan?	Care Plan Considerations	
Review indicators and supporting documentation and draw conclusions. Document:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Document reasons care plan will/will not be developed.	
• Description of problem, need or concern _____ _____ _____		_____	
• Causes and contributing factors, and _____ _____ _____		_____	
• Risk factors related to care area _____ _____ _____		_____	
Note if a referral to another discipline is warranted, if so, to whom and why: _____ _____			
Information regarding this CAA has been transferred to the CAA summary sheet: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Signatures & Dates of Completion/Review			
Signature: _____	Date: _____	Signature: _____	Date: _____
Signature: _____	Date: _____	Signature: _____	Date: _____

INDWELLING URINARY CATHETER JUSTIFICATION

Resident's Name: _____ Room #: _____

Check the reason for the indwelling urinary catheter:

- Coma
- Terminal Illness: _____
- Acute urinary retention or bladder outlet obstruction
- Need for exact measurement of urinary output
- Resident requires prolonged immobilization
- Quad/paraplegia who failed past attempts to remove catheter
- Neurogenic bladder
- Severe contractures resulting in intractable pain during incontinent care
- Other: _____
- of the catheter and how much cc's does the balloon hold
- Attempts made to remove the catheter. Yes No

If No, why? _____ New admission

Resident's responses to the catheter: _____

Catheter care every shift ordered: Yes No

DON or Designee

Date

INDWELLING URINARY CATHETER (IUC) LOG

Name: _____

Room: _____

Diagnosis to support Catheter	What did the facility do to attempt to manage the incontinence and urinary bladder function without the use of an indwelling catheter?	Re-Evaluation Date	Date the Urinary Incontinence & Indwelling Catheter Care Area Assessment completed	Was Resident admitted with IUC?	Date of Care Plan related to use and possible identified risks.
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

INDWELLING URINARY CATHETER (IUC) LOG

Diagnosis to support Catheter	What did the facility do to attempt to manage the incontinence and urinary bladder function without the use of an indwelling catheter?	Re-Evaluation Date	Date the Urinary Incontinence & Indwelling Catheter Care Area Assessment completed	Was Resident admitted with IUC?	Date of Care Plan related to use and possible identified risks.

3-DAY RESIDENT TRACKING/TRENDING BOWEL AND BLADDER PATTERN FORM

RESIDENT NAME: _____

ROOM #: _____

DATE INITIATED: _____

INSTRUCTIONS: PLACE AN "X" THROUGH THE CORRECT SYMBOL(S) EACH TIME YOU CHECK THE RESIDENT.

Nurse Signature: _____

 = LITTLE WET OR  = VERY WET OR = DRY VOID = CONTROLLED VOID  = TAKES A DRINK BM = BOWEL MOVEMENT

DATE: _____							DATE: _____							DATE: _____						
CNA NAME: _____							CNA NAME: _____							CNA NAME: _____						
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5-DAY RESIDENT TRACKING/TRENDING BOWEL AND BLADDER PATTERN FORM

RESIDENT NAME: _____

ROOM #: _____

DATE INITIATED: _____

INSTRUCTIONS: PLACE AN "X" THROUGH THE CORRECT SYMBOL(S) EACH TIME YOU CHECK THE RESIDENT.

 = LITTLE WET OR  = VERY WET OR  = DRY VOID = CONTROLLED VOID  = TAKES A DRINK BM = BOWEL MOVEMENT

DATE: _____							DATE: _____							DATE: _____						
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DATE: _____							DATE: _____						
CNA NAME: _____							CNA NAME: _____						
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Nurses Signature: _____

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RESTORATIVE BOWEL AND/OR BLADDER PROGRAM

RESIDENT NAME: _____ ROOM #: _____ START DATE: _____

Check the appropriate program:

Retraining Program Scheduled Toileting Plan Prompted Voiding Plan Bowel Catheter

Program Removal/Retraining

Date	Day	12 M	1A	2A	3A	4A	5A	6A	7A	8A	9A	10 A	11 A	12 N	1P	2P	3P	4P	5P	6P	7P	8P	9P	10 P	11 P	E	D	N
	1	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/
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	14	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/	/

Circle the hours established during tracking and trending of incontinence and toilet resident within one hour prior to the circled time.

Continue to check resident Q 2hr record code in box. Document code in upper half of box and the number of minutes in the bottom half of the box. After fourteen days, reevaluate need for more time or a change in program.

CODES:

D = Dry **1** = Toileted and urinated **2** = Toileted and had BM **3** = Toileted and had urinary incontinence **4** = Toileted and had bowel incontinence **R** = Refused to be toileted

Over for initials/signatures/dates/outcome

Initial	Signature/Date	Initial	Signature/Date	Initial	Signature/Date	Initial	Signature/Date

Outcome:

Continue Current Program and why:

Change Current Program and why:

Signature/Date: _____

BOWEL & BLADDER PROGRAM

Objectives

Objectives

- Review Regulation
- Review Section H
- Review CAA 6
- Review Bowel & Bladder Program

Regulatory Review

§483.25(e)(1)-(3)

Bowel/Bladder Incontinence, Catheter, UTI

Based on the resident's comprehensive assessment, the facility must ensure that --

Regulatory Review

§483.25(e) (1) The facility must ensure that a resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

Regulatory Review

483.25 (e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that:

- a. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;

Regulatory Review

- b. A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
- c. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

Regulatory Review

For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

Intent of Regulation

The intent of this requirement is to ensure that:

- Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible;

Intent of Regulation

- An indwelling catheter is not used unless there is valid medical justification;
- An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted;

Intent of Regulation

- Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter; and
- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

Definitions

Definitions are provided to clarify clinical terms related to evaluation and treatment of urinary incontinence and catheter use.

- **Bacteremia** - is the presence of bacteria in the bloodstream.
- **Bacteriuria** - is defined as the presence of bacteria in the urine.

Definitions

- **Urinary Incontinence** - is the involuntary loss or leakage of urine. 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:

Definitions

- **Functional Incontinence** - refers to loss of urine that occurs in residents whose urinary tract function is sufficiently intact that they should be able to maintain continence, but who cannot remain continent because of external factors (e.g., inability to utilize the toilet facilities in time);

Definitions

- **Mixed Incontinence** - is the combination of stress incontinence and urge incontinence;
- **Overflow Incontinence** - is associated with leakage of small amounts of urine when the bladder has reached its maximum capacity and has become distended;

Definitions

- **Transient Incontinence** - refers to temporary episodes of urinary incontinence that are reversible once the cause(s) of the episode(s) is (are) identified and treated; and

Definitions

- **Urge Incontinence** - (overactive bladder) is associated with detrusor muscle over-activity (excessive contraction of the smooth muscle in the wall of the urinary bladder resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full).

Definitions

- **Urinary Retention** - is the inability to completely empty the urinary bladder by micturition.

Definitions

- **Urinary Tract Infection** - (UTI) is a clinically detectable condition associated with invasion by disease causing microorganisms of some part of the urinary tract, including the urethra (urethritis), bladder (cystitis), ureters (ureteritis), and/or kidney (pyelonephritis). An infection of the urethra or bladder is classified as a lower tract UTI and infection involving the ureter or kidney is classified as an upper tract UTI.

Definitions

- **Urosepsis** - refers to the systemic inflammatory response to infection (sepsis) that appears to originate from a urinary tract source. It may present with symptoms such as fever, hypotension, reduced urine output, or acute change in mental status.

Overview of Regulation

Incontinence is not normal.

Although aging affects the urinary tract and increases the potential for urinary incontinence, urinary incontinence is not a normal part of aging.

Overview of Regulation

In the older individual, urinary incontinence generally involves psychological, physiological, pharmacological and/or pathological factors or co-morbid conditions (e.g., later stages of dementia, diabetes, prostatectomy, medical conditions involving dysfunction of the central nervous system, urinary tract infections, etc.).

Overview of Regulation

Because urinary incontinence is a symptom of a condition and may be reversible, it is important to understand the causes and to address incontinence to the extent possible. If the underlying condition is not reversible, it is important to treat or manage the incontinence to try to reduce complications.

Overview of Regulation

Many older adults are incontinent of urine prior to admission to a nursing home. Urinary incontinence and related loss of independence are prominent reasons for a nursing home admission.

Overview of Regulation

Articles1 and data currently available, including CMS data (e.g., MDS Active Resident Information Report (Item H0300) at

http://www.cms.gov/MDSPubQlandResRep/04_activeresreport.asp?isSubmitted=res3&v

Overview of Regulation

These articles indicate that more than 50% of the nursing home population experience some degree of urinary incontinence.

Overview of Regulation

Whether the resident is incontinent of urine on admission or develops incontinence after admission, the steps of assessment, monitoring, reviewing, and revising approaches to care (as needed) are essential to managing urinary incontinence and to restoring as much normal bladder function as possible.

Overview of Regulation

Various conditions or situations may aggravate the severity of urinary incontinence in nursing home residents.

Overview of Regulation

In addition, urinary incontinence may be associated with changes in skin integrity, skin irritation or breakdown, urinary tract infections, falls and fractures, sleep disturbances, and psychosocial complications including social withdrawal, embarrassment, loss of dignity, feelings of isolation, and interference with participation in activities.

Overview of Regulation

Various factors common to elderly individuals may increase the risk of infection including: underlying diseases (e.g., diabetes mellitus); medications that affect immune responses to infection (e.g., steroids and chemotherapy; history of multiple antibiotic usage); conditions that cause incontinence; and indwelling urinary catheters.

Overview of Regulation

The urinary tract is a common source of bacteremia in nursing home residents. Urinary tract infection (UTI) is one of the most common infections occurring in nursing homes and is often related to an indwelling urinary catheter. Without a valid clinical rationale for an indwelling catheter, its use is not an acceptable approach to manage urinary incontinence.

Overview of Regulation

Although UTIs can result from the resident's own flora, they may also be the result of microorganisms transmitted by staff when handling the urinary catheter drainage system and/or providing incontinence care.

Hand hygiene remains one of the most effective infection control tools available.

Resources

It is important for the facility to have in place systems/procedures to assure assessments are timely and appropriate; interventions are defined, implemented, monitored, and revised as appropriate in accordance with current standards of practice; and changes in condition are recognized, evaluated, reported to the practitioner, and addressed.

Resources

The medical director and the quality assessment and assurance committee may help the facility evaluate existing strategies for identifying and managing incontinence, catheter use, and UTIs, and ensure that facility policies and procedures are consistent with current standards of practice.

Resources

Research into appropriate practices to prevent, manage, and treat urinary incontinence, urinary catheterization, and UTI continues to evolve.

Many recognized clinical resources on the prevention and management of urinary incontinence, infection, and urinary catheterization exist.

Resources

Some of these resources include:

- The American Medical Directors Association (AMDA) at www.amda.com
- The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives at www.medqic.org
- IDSA webpage at <https://academic.oup.com/cid/article/68/10/e83/5407612>

Resources

- The CMS Sharing Innovations in Quality website at www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp
- Association for Professionals in Infection Control and Epidemiology (APIC) at www.apic.org

Resources

- Centers for Disease Control at www.cdc.gov;
- The Annals of Long Term Care publications at www.mmhc.com
- American Foundation for Urologic Disease, Inc. at www.afud.org and
- The American Geriatrics Society at www.americangeriatrics.org

Resident Choice

In the course of developing and implementing care plan interventions for treatment and services related to achieving the highest practicable level of urinary continence, preventing and treating urinary tract infections, and avoiding the use of indwelling catheters without medical justification, it is important to involve the resident and/or her or his surrogate in care decisions and to consider whether the resident has an advance directive in place.

Resident Choice

In order for a resident to exercise his or her right appropriately to make informed choices about care and treatment or to refuse treatment, the facility and the resident (or the resident's legal representative) must discuss the resident's condition, treatment options, expected outcomes, and consequences of refusing treatment.

Advance Directives

A resident who is at the end of life or in terminal stages of an illness or who has multiple organ system failures may have written directions for his or her treatment goals (or a decision has been made by the resident's surrogate or representative, in accordance with State law).

Advance Directives

Although a facility's care must reflect a resident's wishes as expressed in the Directive, in accordance with State law, the presence of an Advance Directive does not absolve the facility from giving supportive and other pertinent care that is not prohibited by the Advance Directive.

Advance Directives

If the facility has implemented individualized approaches for end-of-life care in keeping with the resident's wishes, and has implemented appropriate efforts to try to stabilize the resident's condition and has provided care based on the assessed needs of the resident,

Advance Directives

then the development, continuation, or progression of urinary incontinence; the insertion and prolonged use of an indwelling urinary catheter; the development of infection or skin related complications from urine or an indwelling catheter may be consistent with regulatory requirements.

Urinary Incontinence

42 CFR 483.25 (d) (2) Urinary Incontinence requires that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Urinary Incontinence

Urinary incontinence generally involves a number of transitory or chronic progressive factors that affect the bladder and/or the urethral sphincter. Any condition, medication, or factor that affects lower urinary tract function, bladder capacity, urination, or the ability to toilet can predispose residents to urinary incontinence and may contribute to incomplete bladder emptying.

Urinary Incontinence

The first steps toward assuring that a resident receives appropriate treatment and services to restore as much bladder function as possible or to treat and manage the incontinence are to identify the resident already experiencing some level of incontinence or at risk of developing urinary incontinence and to complete an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence.

Urinary Incontinence

This is followed by implementing appropriate, individualized interventions that address the incontinence, including the resident's capabilities and underlying factors that can be removed, modified, or stabilized, and by monitoring the effectiveness of the interventions and modifying them, as appropriate.

Urinary Incontinence

The practitioner, may at his or her option, refer residents to various practitioners who specialize in diagnosing and treating conditions that affect urinary function.

Assessment

Factors contributing to urinary incontinence sometimes may be resolved after a careful examination and review of history. In addition, for a resident who is incontinent of urine, determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.

Assessment

A resident should be evaluated at admission and whenever there is a change in cognition, physical ability, or urinary tract function. This evaluation is to include identification of individuals with reversible and irreversible (e.g., bladder tumors and spinal cord disease) causes of incontinence.

Assessment

If the resident has urinary incontinence that has already been investigated, documented, and determined to be irreversible or not significantly improvable, additional studies may be of limited value, unless there has been advancement in available treatments.

Assessment

Documentation of assessment information may be found throughout the medical record, such as in an admission assessment, hospital records, history and physical, and the RAI.

The location of RAI assessment information is identified on the CAA Summary form.

Section H

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at
H0100: Appliances

H0100. Appliances	
↓ Check all that apply	
<input type="checkbox"/>	A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)
<input type="checkbox"/>	B. External catheter
<input type="checkbox"/>	C. Ostomy (including urostomy, ileostomy, and colostomy)
<input type="checkbox"/>	D. Intermittent catheterization
<input type="checkbox"/>	Z. None of the above

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at HO200: Urinary Toileting Program

H0200. Urinary Toileting Program	
Enter Code <input type="checkbox"/>	A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility? 0. No → Skip to H0300, Urinary Continence 1. Yes → Continue to H0200B, Response 9. Unable to determine → Skip to H0200C, Current toileting program or trial
Enter Code <input type="checkbox"/>	B. Response - What was the resident's response to the trial program? 0. No improvement 1. Decreased wetness 2. Completely dry (continent) 9. Unable to determine or trial in progress
Enter Code <input type="checkbox"/>	C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence? 0. No 1. Yes

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at HO300: Urinary Incontinence

H0300. Urinary Continence	
Enter Code <input type="checkbox"/>	<p>Urinary continence - Select the one category that best describes the resident</p> <ol style="list-style-type: none">0. Always continent1. Occasionally incontinent (less than 7 episodes of incontinence)2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)3. Always incontinent (no episodes of continent voiding)9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at HO400: Bowel Incontinence

H0400. Bowel Continence	
Enter Code <input type="checkbox"/>	Bowel continence - Select the one category that best describes the resident <ol style="list-style-type: none">0. Always continent1. Occasionally incontinent (one episode of bowel incontinence)2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement)3. Always incontinent (no episodes of continent bowel movements)9. Not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at HO500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code <input type="checkbox"/>	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

Let's begin with the Assessment

MDS Chapter 3, Section H Bowel and Bladder at
HO600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code <input type="checkbox"/>	Constipation present? 0. No 1. Yes

Section H Definitions

Indwelling Catheter:

- A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

Suprapubic Catheter:

- An indwelling catheter that is placed by a Urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.

Section H Definitions

Nephrostomy Tube:

- A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.

External Catheter:

- Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.

Section H Definitions

Ostomy:

- Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

Urostomy:

- A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g., after extensive surgery or in case of obstruction.

Section H Definitions

Ileostomy:

- A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

Colostomy:

- A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

Section H Definitions

Intermittent Catheterization:

- Sterile insertion and removal of a catheter through the urethra for bladder drainage.

Constipation:

- If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

Section H Definitions

Fecal Impaction:

- A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction.

Care Area Assessment 6

CAA 6 begins with a review of “Modifiable Factors contributing to transitory urinary incontinence” – Areas coded on the MDS should be reflected here with explanation of reason why area was coded.

Then the CAA goes on to review “Other factors and Laboratory Tests” – Again areas coded on the MDS should be reflected here with an explanation of reason why area was coded.

Care Area Assessment 6

The CAA continues with a review of “Diseases and Conditions”, “Type of incontinence”, and “Medications”
Again, areas coded on the MDS should be reflected here with an explanation of reason why the area was coded.

Then the CAA goes on to review “Use of Indwelling Catheter”

Again, areas coded on the MDS should be reflected here with an explanation of reason why area was coded.

Evaluation

It is important that staff, when completing the comprehensive assessment, consider the following:

- Prior history of urinary incontinence,
- Voiding patterns
- Medication review,
- Patterns of fluid intake
- Use of urinary tract stimulants or irritants

Evaluation

- Pelvic and rectal examination to identify physical features that may directly affect urinary incontinence,
- Functional and cognitive capabilities
- Type and frequency of physical assistance necessary to assist the resident to access the toilet
- Pertinent diagnoses

Evaluation

- Identification of and/or potential of developing complications such as skin irritation or breakdown
- Tests or studies indicated to identify the type(s) of urinary incontinence
- Environmental factors and assistive devices that may restrict or facilitate a resident's ability to access the toilet

Types of Urinary Incontinence

Identifying the nature of the incontinence is a key aspect of the assessment and helps identify the appropriate program/interventions to address incontinence. The different type of incontinence are:

- Urge,
- Stress,
- Mixed,
- Overflow,
- Functional and Transient

Interventions

It is important that the facility follow the care process (accurate assessment, care planning, consistent implementation and monitoring of the care plan with evaluation of the effectiveness of the interventions, and revision, as appropriate).

Interventions

Recording and evaluating specific information (such as frequency and times of incontinence and toileting and response to specific interventions) is important for determining progress, changes, or decline.

Interventions

A number of factors may contribute to the decline or lack of improvement in urinary continence, for example:

- Underlying medical conditions, an inaccurate assessment of the resident's type of incontinence (or lack of knowledge about the resident's voiding patterns) may contribute to inappropriate interventions or unnecessary use of an indwelling catheter.

Interventions

Facility practices that may promote achieving the highest practicable level of functioning, may prevent or minimize a decline or lack of improvement in degree of continence include providing treatment and services to address factors that are potentially modifiable, such as:

- Managing pain and/or providing adaptive equipment to improve function for residents suffering from arthritis, contractures, neurological impairments, etc.;

Interventions

- Removing or improving environmental impediments that affect the resident's level of continence (e.g., improved lighting, use of a bedside commode or reducing the distance to the toilet);
- Treating underlying conditions that have a potentially negative impact on the degree of continence (e.g., delirium causing urinary incontinence related to acute confusion);

Interventions

- Possibly adjusting medications affecting continence (e.g., medication cessation, dose reduction, selection of an alternate medication, change in time of administration); and
- Implementing a fluid and/or bowel management program to meet the assessed needs.

Interventions

Options for managing urinary incontinence in nursing home residents include primarily behavioral programs and medication therapy. Other measures and supportive devices used in the management of urinary incontinence and/or urinary retention may include intermittent catheterization; pelvic organ support devices (pessaries); the use of incontinence products, garments and an external collection system for men and women; and environmental accommodation and/or modification.

Programs

Interventions involving the use of programs are among the least invasive approaches to address urinary incontinence and have no known adverse complications.

Programs involve efforts to modify the resident's behavior and/or environment. Critical aspects of a successful program include education of the caregiver and the resident, availability of the staff and the consistent implementation of the interventions.

Programs

Programs that require the resident's cooperation and motivation in order for learning and practice to occur include the following:

- **Bladder Rehabilitation/Bladder Retraining** is a behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

Programs

Depending upon the resident's successful ability to control the urge to void, the intervals between voiding may be increased progressively.

Bladder training generally consists of education, scheduled voiding with systematic delay of voiding, and positive reinforcement. This program is difficult to implement in cognitively impaired residents and may not be successful in frail, elderly, or dependent residents.

Programs

The resident who may be appropriate for a **bladder rehabilitation (retraining) program** is usually fairly independent in activities of daily living, has occasional incontinence, is aware of the need to urinate (void), may wear incontinence products for episodic urine leakage, and has a goal to maintain his/her highest level of continence and decrease urine leakage.

Programs

Successful bladder retraining usually takes at least several weeks.

Residents who are assessed with urge or mixed incontinence and are cognitively intact may be candidates for bladder retraining.

Programs

Pelvic Floor Muscle Rehabilitation also called Kegel and pelvic floor muscle exercise, is performed to strengthen the voluntary periurethral and perivaginal muscles that contribute to the closing force of the urethra and the support of the pelvic organs.

Programs

These exercises are helpful in dealing with urge and stress incontinence. Pelvic floor muscle exercises (PFME) strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment of stress urinary incontinence.

Programs

PFME requires residents who are able and willing to participate, and the implementation of careful instructions and monitoring provided by the facility. Poor resident adherence to the exercises may occur even with close monitoring.

Programs

Programs that are dependent on staff involvement and assistance, as opposed to resident function, include the following:

- **Prompted Voiding** is a technique appropriate for use with dependent or more cognitively impaired residents.

Prompted voiding techniques have been shown to reduce urinary incontinence episodes up to 40% for elderly incontinent nursing home residents, regardless of their type of urinary incontinence or cognitive deficit.

Programs

- **Prompted Voiding** has three components:
 - regular monitoring with encouragement to report continence status;
 - prompting to toilet on a scheduled basis; and
 - praise and positive feedback when the resident is continent and attempts to toilet.

Programs

Residents who are assessed with urge or mixed incontinence and are cognitively impaired may be candidates for prompted voiding.

Programs

Habit Training/Scheduled Voiding is a technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits.

Unlike bladder retraining, there is no systematic effort to encourage the resident to delay voiding and resist urges.

Programs

Habit training includes timed voiding with the interval based on the resident's usual voiding schedule or pattern.

Scheduled voiding is timed voiding, usually every three to four hours while awake. Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.

Medication Therapy

Medications are often used to treat specific types of incontinence:

- Stress Incontinence
- Overactive Bladder
- Urge Incontinence
- Urinary Urgency
- Frequency
- Nocturia

Pessary

A **Pessary** is an intra-vaginal device used to treat pelvic muscle relaxation or prolapse of pelvic organs. Women whose urine retention or urinary incontinence is exacerbated by bladder or uterine prolapse may benefit from placement of a pessary.

Pessary

Female residents may be admitted to the nursing home with a pessary device.

The assessment should note whether the resident has a pessary in place or has had a history of successful pessary use.

If a pessary is to be used, it is important to develop a plan of care for ongoing management and for the prevention of and monitoring for complications.

Other Devices

Absorbent Products, Toileting Devices, External Collection Devices.

Absorbent incontinence products include:

- perineal pads or panty liners for slight leakage;
- undergarments and protective underwear for moderate to heavy leakage (called pull-ups);
- guards and drip collection pouches for men; and
- products (called adult briefs) for moderate or heavy loss.

Other Devices

Absorbent Products, Toileting Devices, External Collection Devices.

Absorbent products can be a useful, rational way to manage incontinence; however, every absorbent product has a saturation point. Factors contributing to the selection of the type of product to be used should include the severity of incontinence, gender, fit, and ease of use.

Other Devices

Absorbent Products, Toileting Devices, External Collection Devices.

Advantages of using absorbent products to manage urinary incontinence include the ability to contain urine (some may wick the urine away from the skin), provide protection for clothing, and preserve the resident's dignity and comfort.

Other Devices

Absorbent Products, Toileting Devices, External Collection Devices.

Disadvantages of absorbent products are the impact on the resident's dignity, cost, the association with skin breakdown and irritation, and the amount of time needed to check and change them.

Skin-Related Complications

Skin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown. Moisture may make the skin more susceptible to damage from friction and shear during repositioning.

Skin-Related Complications

One key to preventing skin breakdown is to keep the perineal skin clean and dry.

Research has shown that a soap and water regimen alone may be less effective in preventing skin breakdown compared with moisture barriers and no-rinse incontinence cleansers.

Catheterization

42 CFR 483.25 (d) (1) Urinary Incontinence requires that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

Catheterization

Some residents are admitted to the facility with indwelling catheters that were placed elsewhere (e.g., during a recent acute hospitalization). The facility is responsible for the assessment of the resident at risk for urinary catheterization and/or the ongoing assessment for the resident who currently has a catheter. This is followed by implementation of appropriate individualized interventions and monitoring for the effectiveness of the interventions.

Evaluation

A resident may be admitted to the facility with or without an indwelling urinary catheter (urethral or suprapubic) and may be continent or incontinent of urine. Regardless of the admission status, a comprehensive assessment should address those factors that predispose the resident to the development of urinary incontinence and the use of an indwelling urinary catheter.

Evaluation

An admission evaluation of the resident's medical history and a physical examination helps identify the resident at risk for requiring the use of an indwelling urinary catheter.

Evaluation

This evaluation is to include detection of reversible causes of incontinence and identification of individuals with incontinence caused by conditions that may not be reversible, such as bladder tumors and spinal cord diseases.

Evaluation

The assessment of continence/incontinence is based upon an interdisciplinary review. The comprehensive assessment should include underlying factors supporting the medical justification for the initiation and continuing need for catheter use, determination of which factors can be modified or reversed (or rationale for why those factors should not be modified), and the development of a plan for removal.

Evaluation

For the resident with an indwelling catheter, the facility's documented assessment and staff knowledge of the resident should include information to support the use of an indwelling catheter.

Evaluation

The assessment should include consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; and consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort and bleeding.

Intermittent Catheterization

Intermittent catheterization can often manage overflow incontinence effectively. Residents who have new onset incontinence from a transient, hypotonic/atonic bladder (usually seen following catheterization in the hospital) may benefit from intermittent bladder catheterization until the bladder tone returns, usually up to approximately 7 days. A voiding trial and post void residual can help identify when bladder tone has returned.

Indwelling Catheter Use

The facility's documented assessment and staff approach to the resident should be based on evidence to support the use of an indwelling catheter.

Examples of Appropriate Indications for Indwelling Urethral Catheter Use:

- Resident has acute urinary retention or bladder outlet obstruction;
- Need for accurate measurements of urinary output;

Indwelling Catheter Use

- To assist in healing of open sacral or perineal wounds in incontinent residents;
- Resident requires prolonged immobilization (e.g., potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures);and
- To improve comfort for end-of-life care, if needed.

Catheter Complications

An indwelling catheter may be associated with significant complications, including:

- bacteremia,
- febrile episodes,
- bladder stones,
- fistula formation,
- erosion of the urethra,
- epididymitis,
- chronic renal inflammation and
- pyelonephritis.

Catheter Complications

In addition, indwelling catheters are prone to blockage.

Risk factors for catheter blockage include:

- alkaline urine,
- poor urine flow,
- proteinuria, and
- preexisting bladder stones.

Catheter Complications

***In the absence of evidence indicating blockage, catheters need not be changed routinely as long as monitoring is adequate. (Per regulation as set by CDC recommendations)

Based on the resident's individualized assessment, the catheter may need to be changed more or less often than every 30 days.

Catheter Complications

Research has shown that catheterization is an important, potentially modifiable, risk factor for UTI.

By the 30th day of catheterization, bacteriuria is nearly universal.

Catheter Complications

The potential for complications can be reduced by:

- Identifying specific clinical indications for the use of an indwelling catheter;
- Assessing whether other treatments and services would appropriately address those conditions;
and

Catheter Complications

- Assessing whether residents are at risk for other possible complications resulting from the continuing use of the catheter, such as obstruction resulting from catheter encrustation, urethral erosion, bladder spasms, hematuria, and leakage around the catheter.

Physician Orders

Physician Orders should include at a minimum the following:

- Size of catheter tubing and bulb size
- Diagnosis
- Catheter Care every shift
- Irrigation as needed for occlusion
- Frequency/When to change***

*****Note:** CDC guidelines related to Indwelling Catheters suggests that catheters not be routinely changed. (i.e., monthly) see the following link for more information

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3362394>

Bowel and Bladder Program

- Review Policy and Procedures
- Review Forms
- Review Competency
- Provide Demonstration
- Conduct Return Demonstration Competencies

Q & A

Questions???



Thank you
Bowel and Bladder Program



To learn more about this topic please contact Tamra M. Adrian, RN, HCRM, CDP, Director of Regulatory Services at tamra@rbhealthpartners.com
Click [HERE](#) for more info about this Presenter



You may also contact Robin A. Bleier, President with regards to this or other services at robin@rbhealthpartners.com or call us at 727.786.3032.
Click [HERE](#) for more info about this Presenter

**BOWEL & BLADDER PROGRAM
PRE-TEST**

Name: _____

Date: _____

1. The Federal Regulation that will be discussed during today's training will be?
 - a. Pressure Ulcers
 - b. Enteral Feedings
 - c. Notification of Change
 - d. Incontinence
 - e. None of the above

2. The intent of the regulation is to ensure which of the following?
 - a. Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible
 - b. An indwelling catheter is not used unless there is valid medical justification
 - c. An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted
 - d. Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter
 - e. A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible
 - f. All of the above

3. Urinary Incontinence - is the involuntary loss or leakage of urine.
 - a. True
 - b. False

4. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time.
 - a. True
 - b. False

5. Some of the more common types include:
 - a. Functional Incontinence
 - b. Dripping Incontinence
 - c. Urge Incontinence
 - d. A and C

6. Transient Incontinence - refers to temporary episodes of urinary incontinence that are reversible once the cause(s) of the episode(s) is (are) identified and treated:
 - a. True
 - b. False

7. Urinary Retention - is the inability to completely empty the urinary bladder by micturition?
 - a. True
 - b. False

8. Urinary incontinence is a normal part of aging.
 - a. True
 - b. False

9. The following are essential to managing urinary incontinence and to restoring as much normal bladder function as possible:
 - a. assessment
 - b. monitoring
 - c. reviewing
 - d. revising approaches to care
 - e. All of the above

10. Urinary tract infection (UTI) is one of the most common infections occurring in nursing homes and is often related to an indwelling urinary catheter.
 - a. True
 - b. False

11. UTIs can be a result of the residents own flora as well as which of the following?
 - a. Microorganisms transmitted by staff when handling the urinary catheter drainage system.
 - b. Microorganisms transmitted by staff when providing incontinence care.
 - c. Both A and B.

12. Every resident who is admitted, readmitted or who experiences a significant change in status requires an evaluation of continence status?
 - a. True
 - b. False

13. It is the Night Nurse's responsibility to complete the resident's continence evaluation?
 - a. True
 - b. False

14. When should the continence tracking and trending form be initiated?
- a. Upon admission
 - b. Upon readmission
 - c. Upon removal of an indwelling catheter
 - d. Upon identification of a significant change in the resident's condition
 - e. All of the above
15. Who is responsible for the documentation for the tracking and trending?
- a. The 3 – 11 Supervisor
 - b. The admitting nurse
 - c. The Certified Nursing Assistant (CNA)
 - d. The Director of Nursing
16. After the tracking and trending form has been completed it is reviewed along with the continence evaluation to determine if the resident would benefit from a Bowel and Bladder Restorative Program.
- a. True
 - b. False
17. For some residents to remain or regain continence it will be important for the CNA to adhere to the scheduled toileting times?
- a. True
 - b. False
18. Monitoring a resident's skin integrity during episodes of incontinence is an important aspect of nursing care.
- a. True
 - b. False
19. A resident with dementia is going to be and will remain incontinent; there is nothing we can do to improve it.
- a. True
 - b. False
20. Providing adequate incontinent care can reduce the resident's risk of developing a UTI?
- a. True
 - b. False

Score: _____

Pass: []

Additional Training Needed: []

**BOWEL & BLADDER PROGRAM
POST-TEST**

Name: _____

Date: _____

1. The Federal Regulation that was discussed during today's training was for?
 - a. Pressure Ulcers
 - b. Enteral Feedings
 - c. Notification of Change
 - d. Incontinence
 - e. None of the above

2. The intent of the regulation is to ensure which of the following?
 - a. Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible
 - b. An indwelling catheter is not used unless there is valid medical justification
 - c. An indwelling catheter for which continuing use is not medically justified is discontinued as soon as clinically warranted
 - d. Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter
 - e. A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible
 - f. All of the above

3. Urinary Incontinence - is the involuntary loss or leakage of urine.
 - a. True
 - b. False

4. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time.
 - a. True
 - b. False

5. Some of the more common types include:
 - a. Functional Incontinence
 - b. Dripping Incontinence
 - c. Urge Incontinence
 - d. A and C

6. Transient Incontinence - refers to temporary episodes of urinary incontinence that are reversible once the cause(s) of the episode(s) is (are) identified and treated:
- True
 - False
7. Urinary Retention - is the inability to completely empty the urinary bladder by micturition?
- True
 - False
8. Urinary incontinence is a normal part of aging.
- True
 - False
9. The following are essential to managing urinary incontinence and to restoring as much normal bladder function as possible:
- assessment
 - monitoring
 - reviewing
 - revising approaches to care
 - All of the above
10. Urinary tract infection (UTI) is one of the most common infections occurring in nursing homes and is often related to an indwelling urinary catheter.
- True
 - False
11. UTIs can be a result of the residents own flora as well as which of the following?
- Microorganisms transmitted by staff when handling the urinary catheter drainage system.
 - Microorganisms transmitted by staff when providing incontinence care.
 - Both A and B.
12. Every resident who is admitted, readmitted or who experiences a significant change in status requires an evaluation of continence status?
- True
 - False
13. It is the Night Nurse's responsibility to complete the resident's continence evaluation?
- True
 - False

14. When should the continence tracking and trending form be initiated?
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- a. True
 - b. False
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- a. True
 - b. False
18. Monitoring a resident's skin integrity during episodes of incontinence is an important aspect of nursing care.
- a. True
 - b. False
19. A resident with dementia is going to be and will remain incontinent; there is nothing we can do to improve it.
- a. True
 - b. False
20. Providing adequate incontinent care can reduce the resident's risk of developing a UTI?
- a. True
 - b. False

Score: _____

Pass: []

Additional Training Needed: []

**BOWEL & BLADDER PROGRAM
ANSWER KEY**

Name: _____

Date: _____

1. The Federal Regulation that was discussed during today's training was for?
 - a. Pressure Ulcers
 - b. Enteral Feedings
 - c. Notification of Change
 - d. **Urinary Incontinence**
 - e. None of the above

2. The intent of the regulation is to ensure which of the following?
 - a. Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible
 - b. An indwelling catheter is not used unless there is valid medical justification
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 - d. Services are provided to restore or improve normal bladder function to the extent possible, after the removal of the catheter
 - e. A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible
 - f. **All of the above**

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4. There are several types of urinary incontinence, and the individual resident may experience more than one type at a time.
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5. Some of the more common types include:
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 - d. **A and C**

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 - d. revising approaches to care
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- a. **True**
 - b. False
13. It is the Night Nurse's responsibility to complete the resident's continence evaluation?
- a. True
 - b. **False**

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19. A resident with dementia is going to be and will remain incontinent; there is nothing we can do to improve it.
- a. True
 - b. **False**
20. Providing adequate incontinent care can reduce the resident's risk of developing a UTI?
- a. **True**
 - b. False

CATHETER INSERTION COMPETENCY CHECK-OFF

	Passed	Passed - After Verbal Review	Fail - Need Further Training
Check physician's orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Identify the resident & explain the procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform hand hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assemble materials and supplies as needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleans area and set supplies on barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform hand hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open catheter kit utilizing aseptic technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put on sterile gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleanses area around urethra meatus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inserts indwelling catheter without difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine return noted in tubing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inflates bulb with appropriate amount	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secures catheter to leg strap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repositions resident for comfort, as indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removes/Discards waste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removes gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wash hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appropriately documents on TAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Documents in clinical record	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can state when to notify MD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments

Date: _____ Nurse's Name: _____

RN Validator Signature: _____

CATHETER CARE COMPETENCY CHECK-OFF

	Passed	Passed - After Verbal Review	Fail - Need Further Training
Knocks and awaits permission to enter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greets resident and addresses by name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Introduces self and Explains the procedure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performs hand hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleans area and sets up supplies on barrier	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washes hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Put on gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses one side/edge of wipe or washcloth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Begins in the front peri-area	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses same technique to cleanse tubing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cleans tubing from meatus to collection bag	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assists resident in rolling over	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uses second wipe to complete backside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Using same single stroke technique	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repositions resident for comfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removes gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Washes hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Removes and discards waste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ensures call light and personal items in reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can state when to inform nurse of skin issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments

Date: _____ CNA's Name: _____

RN Validator Signature: _____