Urinary Incontinence Critical Element Pathway

Use this protocol for a sampled resident with urinary incontinence. If the concern is related to the resident's bowel function, use the General CE Pathway.

Review the following to guide your observations and interviews:

☐ Review the most current comprehensive (i.e., admission, annual, significant change, or a significant correction to a prior comprehensive) and most recent quarterly (if the comprehensive isn't the most recent assessment) MDS/CAAS for C - cognitive status, G - mobility, transfer, and toileting status, H - urinary continence and toileting program, N - meds, and O - OT, PT, or restorative services,

☐ Care plan (e.g., continence status, individualized toileting program [e.g., retraining, habit training, prompted void, scheduled voiding or check and change], toileting assistance from staff, assistive devices, or other interventions to address the resident's incontinence),

☐ Physician's orders (e.g., medications that may impact continence like sedatives, diuretics or narcotics, and therapy or restorative pertinent to toileting), and

☐ Pertinent diagnosis.

Observation

Make observations as appropriate, over various shifts to corroborate the information obtained during the record review. You may also find it important to observe for information obtained from staff interviews. Potential pertinent observations are listed below.

☐ Observe toileting and peri-care.

Note: *When the investigation necessitates the observation of toileting or incontinence care, maintaining the resident's dignity is of the utmost importance.*

- Did staff provide assistance to prevent incontinence episodes? If not, how long was the resident not toileted? Is the resident wet? Linens saturated? Are there perineal skin problems (e.g., macerated)?
- Is the resident embarrassed or humiliated if incontinent?
- Does staff provide privacy when providing care to the resident?
- Does staff treat the resident with dignity?
- Does staff inform the resident what they are doing before they act?
- Watch for breaks in infection control practices.
- Does staff implement appropriate hygiene measures (e.g., cleansing, rinsing, drying, applying protective moisture barriers) to prevent skin breakdown if incontinent?
- Is the call light in reach? Does staff respond in a timely manner?
- Is the pathway unobstructed to the bathroom?
- Are assistive devices provided as needed (e.g., toilet seat, grab bars, urinal, bedpan, or commode)?
- Did the resident have breakthrough incontinence? If so, what did the staff do?

☐ Are care-planned interventions in place?

Interview

*As part of the investigation, surveyors should attempt to initially interview **the most appropriate direct care staff member.** Your interview question should be specific to the investigation at hand and based on findings from the record review and observations. Interview the treatment or wound care nurse. Consider interviewing the DON, MD, CNP or PA to complete the investigation.*

Resident and/or representative:

- ☐ Did your urinary incontinence begin in the facility? If so, did staff work with you to determine what type of incontinence you are experiencing?
- ☐ Did staff discuss with you how they plan to improve your incontinence?
- ☐ What type of interventions are done? (Ask about specific interventions – e.g., voiding program).
  - Does staff provide timely assistance? If not, have you had any incontinent episodes? How did that make you feel?
  - Has staff offered and provided you with assistive devices?
  - Did staff show you how to use the assistive device?
- ☐ If you know the resident independently goes to the bathroom: Can you get to the bathroom/commode?
- ☐ Do you have a history of UTIs, UTI-related pain, or perineal issues?
- ☐ If you know the resident has refused care: Did the staff provide you with other options of treatment or did staff provide you with education on what might happen if you do not follow the treatment plans?
- ☐ Has your incontinence caused you to be less involved in activities you enjoy?
- ☐ Has your incontinence caused a change in your mood or ability to function?
- ☐ Is your incontinence getting worse? If so, do you know why you aren't getting better?

Staff:
Nurse Aide:

- ☐ Are you familiar with the resident's care?
- ☐ Is the resident incontinent of urine? If so, ask:
  - How often is the resident incontinent? How long has the resident been incontinent?
- ☐ How often are you supposed to toilet the resident?
- ☐ How much assistance does the resident need with toileting?
- ☐ How do you promote the resident's participation to the extent possible?
- ☐ Does the resident have a UTI or skin problems because of incontinence? If so, who do you report it to and how is it being treated?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident's incontinence getting worse? If so, did you report it (to whom and when) and did the toileting plan change?
- ☐ How were you trained to do peri-care?
- ☐ Ask about any concerns based on your investigation.

Staff:
Therapy and/or Restorative Manager:

- ☐ When did therapy/restorative start working with the resident?
- ☐ What is therapy/restorative doing to address the resident's incontinence (e.g., balance, muscle strengthening, or transfers)?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ What are the current goals for the resident?
- ☐ Is the resident's incontinence getting worse? If so, did the treatment plan change?
- ☐ Ask about any concerns based on your investigation.

Staff:

Nurse:

- ☐ Are you familiar with the resident's care?
- ☐ What are the resident's risk factors to become incontinent of urine?
- ☐ Is the resident incontinent of urine? If so, ask:
  - How often is the resident incontinent? How long has the resident been incontinent?
  - If incontinence is recent: Who was notified of the incontinence and when were they notified?
  - What type of urinary incontinence does the resident have (e.g., stress or urge incontinence)?
- ☐ Were voiding patterns assessed?
- ☐ Was a continence program implemented? If not, how did you decide that he/she would not benefit from a program?
- ☐ What are you doing to address the resident's incontinence?
- ☐ How did you identify that the interventions were suitable for this resident?
- ☐ Do you involve the resident/representative in decisions regarding interventions? If so, how? Does the resident have a UTI or perineal skin problems? If so, who do you report it to and how is it being treated?
- ☐ Does the resident refuse? What do you do if the resident refuses?
- ☐ Is the resident's incontinence getting worse? If so, did you report it (to whom and when) and did the toileting plan change?
- ☐ How did you train staff to do peri-care?
- ☐ How do you monitor staff to ensure they are implementing care-planned interventions?
- ☐ Ask about any concerns based on your investigation.

Record Review

You may need to return to the record to corroborate information from the observations and interviews. Potential pertinent items in the record are listed below.

- ☐ Review nursing notes and bladder assessments.
  - Did staff identify the type of urinary incontinence?
  - Did staff assess the incontinence (e.g., voiding patterns, fluid intake) and follow the continence program as often as ordered?
  - Did staff identify the type and frequency of toileting assistance the resident would benefit from?
  - Is there documentation that indicates the incontinence has improved, been maintained, or declined?
- ☐ Are the underlying risk factors identified (e.g., physical functioning, meds that effect continence)?
- ☐ Has the toileting program been put in place?
- ☐ Review laboratory results pertinent to UTIs.
- ☐ Are environmental factors that may impede bladder continence identified and addressed (e.g., access to toilet, call light, type of clothing, restraint use)? Has the care plan been revised to reflect any changes in incontinence?
- ☐ Does your observation of the resident match the incontinence description in the clinical record?
- ☐ Are perineal skin problems from prolonged exposure to urine and UTI-related pain assessed and treatment measures documented?
- ☐ Review facility policies and procedures with regard to continence.

Urinary Incontinence Critical Element Pathway

Make compliance decisions below by answering the six Critical Elements.

Note: *Remember if the facility failed to complete a comprehensive assessment resulting in a citation at F272, surveyors should not cite F279 and F280 as the facility could not have developed or revised a plan of care based on a comprehensive assessment they did not complete. If further guidance is needed, surveyors should refer to the regulation, IG, and investigative protocol as they conduct the investigation.*

Critical Element

1. If the condition or risks were present at the time of the required assessment, did the facility comprehensively assess the resident's physical, mental, and psychosocial needs to identify the risks and/or determine underlying causes (to the extent possible) for the resident's urinary incontinence, and the impact upon the resident's function, mood, and cognition?
   If No, cite F272
   NA, condition/risks were identified after completion of the required comprehensive assessment and did not meet the criteria for a significant change MDS OR a comprehensive assessment is not required yet.

2. Did the facility develop a plan of care with interventions and measurable goals, in accordance with the assessment, resident's wishes, and current standards of practice, to address the resident's incontinence and/or restore as much bladder function as possible?
   If No, cite F279
   NA, the comprehensive assessment was not completed OR a comprehensive care plan is not required yet.

3. Did the facility provide or arrange services to be provided by qualified persons in accordance with the resident's written plan of care?
   If No, cite F282
   NA, no provision in the written plan of care for the concern being evaluated.

4. Did the facility reassess the effectiveness of the interventions and review and revise the plan of care (with input from the resident or representative, to the extent possible), if necessary, to meet the needs of the resident?
   If No, cite F280
   NA, the comprehensive assessment was not completed OR the care plan was not developed OR the care plan did not have to be revised

5. Based on observation, interviews, and record review, did the facility provide appropriate treatment and services to, 1) prevent UTIs for a resident who is incontinent of bladder, and 2) restore as much normal bladder function as possible?
   If No, cite F315

6. For a resident who is on a check and change program, is unable to participate in a program to restore continence, and is unable to carry out ADLs, did the facility provide the necessary services?
   If No, cite F312
   NA, the resident is not on a check and change program, can participate in a toileting program and is able to carry out ADLs.

Other Tags and Care Areas to consider: F155, Notification of Change (F157), Abuse (F223, F224, F226), Dignity (F241), Choices (F155, F242, F246), F271, F274, F278, F281, F309 (General Pathway), Pressure Ulcer (F314), Behavioral/Emotional Status (F309, F319, F320), Hydration (F327), Sufficient Staffing (F353, F354), F385, Rehab and Restorative (F311, F406), Infection Control (F441), F498, F514, QA&A (F520).

Notes: