1. Which of the following are components of a urinary continence assessment?
   a. Medication review
   b. Patterns of fluid intake
   c. Voiding patterns
   d. All of the above

2. Which of the following statements is NOT true?
   a. Most elderly residents can participate in bladder re-training
   b. Resident with dementia may benefit from prompted or habit voiding programs
   c. The most common cause of incontinence is urge incontinence
   d. All of the above

3. Which of the following symptoms indicate a UTI in a resident without a catheter?
   a. Urine culture
   b. Fever
   c. Change in character of urine
   d. None of the above, in absence of other symptoms, indicates a UTI

4. Which of the following is NOT justification for an indwelling catheter?
   a. Stage 3 or 4 with contamination of urine that has impeded healing
   b. Need for accurate intake and output
   c. A terminal illness that makes positioning uncomfortable
   d. All of the above

5. Which of the following is not an acceptable practice?
   a. Notify physician and family of symptomatic UTI
   b. Routine follow-up culture after course of antibiotics
   c. Re-assess after 2 recurrent UTIs within 6 months
   d. None of the above
POST TEST ANSWERS

1. Which of the following are components of a urinary continence assessment?
   
   - e. Medication review
   - f. Patterns of fluid intake
   - g. Voiding patterns
   - h. All of the above  
     
     D

3. Which of the following statements is NOT true?
   
   - a. Most elderly residents can participate in bladder re-training.
   - b. Resident with dementia may benefit from prompted or habit voiding programs.
   - c. The most common cause of incontinence is urge incontinence.
   - d. All of the above  
     
     A

3. Which of the following symptoms indicate a UTI in a resident without a catheter?
   
   - e. Urine culture
   - f. Fever.
   - g. Change in character of urine.
   - h. None of the above, in absence of other symptoms, indicates a UTI.  
     
     D

4. Which of the following is NOT justification for an indwelling catheter?
   
   - e. Stage 3 or 4 with contamination of urine that has impeded healing.
   - f. Need for accurate intake and output.
   - g. A terminal illness that makes positioning uncomfortable.
   - h. All of the above.  
     
     B

5. Which of the following is not an acceptable practice?
   
   - a. Notify physician and family of symptomatic UTI.
   - b. Routine follow-up culture after course of antibiotics.
   - c. Re-assess after 2 recurrent UTIs within 6 months.
   - d. None of the above.  
     
     B
Bowel and Bladder Management Program

Bowel and Bladder Program Key Components

- QAC should ensure all Key Components are in place and effective
  1. Admission Assessment/Identify all risk factors
     - Initiate voiding pattern
     - Initial care plan
     - Indwelling Catheter justification
  2. Ongoing Assessment and Monitoring
     - Evaluate voiding pattern
Bowel and Bladder Program Key Components

– Care plan updates/MDS completion
– Comprehensive Bowel and Bladder Assessment
– Development of B&B program that meets residents needs

3. Care Plan Protocols
– Develop and utilize B&B toileting programs and care delivery protocols
– Care plan components

Bowel and Bladder Program Key Components

—Bladder Management Program
  —Bladder Retraining
  —Habit Voiding/Scheduled Toileting
  —Prompted Voiding
  —Incontinence Management
  —Indwelling Catheters
  —Bowel Management Program

4. QA Oversight/Routine Audits
Admission Assessment

Admission

• Upon admission, all residents will be initially assessed to elimination status as part of the admission assessment

• Standardized risk tool for B&B
  — Identify risk factors
  — Initial potential for bladder retraining or scheduled toileting

Admission

• As part of the initial nursing assessment, a nurse will perform a Bowel and Bladder Risk Score

• This assessment will measure key clinical information related to elimination
  – History of incontinence or continence
  – Cognitive status
  – Mobility factors
  – Medical factors
  – Risk Medications
  – Fluid needs
Within 24 Hours of Admission

- Within 24 hours of admission
  - Initiate voiding pattern for a minimum of 3 days if determined incontinent
- Initiate a preliminary care plan protocol based on initial assessment.
- A care plan is implemented within 24 hours based on initial assessment to address:
  - Fluids needs
  - ADL needs
Within 24 Hours of Admission

- Toileting plan (e.g., commode, bedpan, bathroom, urinal, adult briefs)
- Recommend toileting protocol until resident’s voiding pattern is known.
  - For example: “Check and toilet every 2 hours during day and one time at night.” Health Center should establish this protocol based on their residents’ needs and acuity.
Within 24 Hours of Admission

Foley Catheters

• When an indwelling catheter is in place:
  – Assess for justification
  – If not justified, remove catheter

Within 24 Hours of Admission

• Example Initial Care Plan:
  • Need statement: Potential for incontinent episodes
  • Goal: Establish a toileting regime to minimize incontinent episodes
Within 24 Hours of Admission

- **Example Initial Care Plan:**
- **Interventions:**
  - Encourage fluids and offer fluids before/after toileting.
  - Ask to identify need to void, prompt to void, or provide assistance.
  - Check resident and toilet every two hours during the day.
  - Check one time during night.
  - Complete voiding pattern.
  - Toilet using: ________________.

Indwelling Catheters

- Part of the initial assessment will determine if the indwelling catheter is justified
- This justification is documented via physician diagnosis or health conditions.
- **F-tag 315 Guidance:**
  - Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by:
Indwelling Catheters

- Documented post void residual (PVR) volumes in a range over 200 milliliters (ml)
- Inability to manage the retention/incontinence with intermittent catheterization
- Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction
- Contamination of Stage III or IV pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence
- Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain

If the catheter is not justified, initiate removal procedures immediately. Resident would be placed on bladder re-training

- Initiate voiding pattern/scheduled toileting plan based on overall Bowel and Bladder Risk Tool. Initially, toilet every 2 hours during day and one time at night.
- Place on alert status and document to status every shift during training period of two weeks
- Provide fluids and toilet every two hours initially
Indwelling Catheters

- Place on Intake and Output
- Encourage resident to recognize need to void.
- If output is low, perform a Post Void Residual test with a straight catheter or bladder scanner.
- Modify toileting schedule as needed during 2 to 3 week training period.
Ongoing Assessment and Monitoring

First 14 days after admission during MDS and CAA admission process:

• After 3 days, the designated nurse will evaluate voiding pattern and document in nurses’ notes
• Based on results the care plan is updated to an ongoing elimination plan based on bladder/bowel management program
  – If needed, the voiding pattern data collection can be continued for another 3 or 7 days

Ongoing Assessment and Monitoring

The Voiding Pattern process identifies the following:

• Toileting ability
• Bladder storage ability
• Frequency of wets per day
• Mental responsiveness of resident
• Natural patterns of voiding
Ongoing Assessment and Monitoring

- What behaviors or gestures indicate a need to void in a resident who cannot easily verbalize need to void?

- At what times does the resident void
  - During therapy
  - Before, during, or after meals
  - While sleeping
  - During baths
  - During transfer to and from bed
  - During activity— which activity?

The summary of assessment and plan can be documented during the first 14 days in one of the following ways:

- Comprehensive Bowel and Bladder Assessment form (meets CAA requirements), or
- A summary note is written (using Incontinence CAA for guidance), or;
- Summary documentation when the Incontinence/Indwelling Catheter CAA (Care Area Assessment) is completed assuming the CAA is triggered.
**Voiding Pattern**

- The voiding pattern form will track the following:
  - Resident is checked every hour and toileted every 2 hours and checked at night
  - The resident is only awakened at night if a voiding pattern determines need (health center specific guidelines can be used).
    - If not awoken at night, then an early AM check would be suggested e.g. 6 a.m.

- Bladder: Observe if Wet, Dry, or Voided
- Bowel: Observe if Soiled, Dry, or Bowel Movement
- If voided, then how voided: Toilet self, Assisted Toileting, Resident uncooperative
- Possible other items: How voided - bedpan, urinal, commode toilet, or assisted to toilet but would not void
MDS/CAA Process

- The MDS is completed within 14 days of admit
- If the Incontinent/Indwelling Catheter CAA (Care Area Assessment) is triggered, documentation should demonstrate review of CAA guidelines with a summary of risk factors and contributors to incontinence and decision regarding care plan.
**MDS/CAA Process**

- If a comprehensive summary note has already been written as part of your bowel and bladder assessment:
  - Reference back to that assessment document on the CAA form; no need to duplicate

**Voiding Pattern**

- Document in nurses notes what times the voiding pattern demonstrates that resident voids, and the toileting plan to be implemented.
- Based on the voiding pattern results and assessment, the care plan is updated to ongoing elimination plan based on choice bladder/bowel management program.
Toileting Plan

• The plan should be:
  – Resident specific
  – Individualized
  – Communicated to resident and staff either by hours or resident pattern
  – This individualized plan is needed to be able to code as “scheduled toileting” on the MDS.

Voiding Pattern

– Examples:
  – Toilet in early a.m., just before meals and before going to bed usually around 8:30 p.m. Do not wake up during night.
  – Toileting even hours during day starting at 6 a.m. and ending at 8 p.m.
  – Do not awake to toileting during night.
  – Awake at 3 a.m. to encourage voiding.

• If needed, the voiding pattern data collection can be continued for another 3 or 7 days if additional data is needed.
Quarterly Review

Ongoing and Quarterly MDS and Assessments:
• Quarterly MDS/Significant Change if needed
• Evaluation of effectiveness of current program, with identification of change in status or risk factors.

• Review bladder and bowel status, care plan interventions, and goals using MDS coding of elimination and Risk Tool
  – If the health center performs monthly summaries, include a review of elimination status, progress toward goal and effectiveness of current toileting plan.
Noted Decline

- If decline is noted with an increase in incontinence episodes, initiate a full bowel and bladder assessment (decline may be one of two qualifiers for a Significant Change in Status MDS):
  - Initiate a voiding pattern for 3 days
  - Evaluate voiding pattern and complete a comprehensive assessment

Assessment and Care Plan

- Document assessment and care plan revision using one of the following three methods:
  - Comprehensive Bowel and Bladder Assessment form (meets CAA requirements), or
  - A summary note is written (using Incontinence CAA for guidance), or
  - Summary documentation when the Incontinence/Indwelling Catheter CAA (Resident Assessment Protocol) is completed assuming the CAA is triggered as part of an annual or Significant Change in Status Assessment.
Potential Risk Factors

• Regardless of how the CAA and assessment process is documented, the following areas should be considered and ruled out or addressed as a risk factor for that resident:

Prior History of Urinary Incontinence

Prior history of urinary incontinence
• Onset, duration, and characteristics
• Precipitants of urinary incontinence
• Associated symptoms (e.g., dysuria, polyuria, hesitancy)
• Previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI
Voiding Patterns

Voiding patterns
• Frequency
• Volume
• Nighttime or daytime
• Quality of stream
• Voiding pattern over several days (if already urinary incontinent)

Patterns of Fluid Intake

Patterns of Fluid Intake
• Amounts
• Time of day
• Alterations and potential complications
  – decreased or increased urine output
Medication Review

- Anticholinergic properties
- Sedative/hypnotics
- Narcotics, alpha-adrenergic agonists
- Calcium channel blockers
- May cause urinary retention and possible overflow incontinence
- May cause sedation leading to functional incontinence
- May cause urinary retention in men or antagonists may cause stress incontinence in women
- May cause urinary retention

Urinary Tract Stimulants or Irritants

- Use of urinary tract stimulants or irritants
- frequent caffeine intake
Pelvic and Rectal Examination

- **Pelvic and rectal examination** to identify physical features that may directly affect urinary incontinence
  - prolapsed uterus or bladder
  - prostate enlargement
  - significant constipation or fecal impaction
  - use of a urinary catheter
  - atrophic vaginitis
  - distended bladder
  - bladder spasm

Functional and Cognitive Capabilities

Functional and cognitive capabilities
- Could enhance urinary continence
- Cause limitations that could adversely affect continence
  - impaired cognitive function
  - dementia
  - impaired mobility
Physical Assistance

Type and frequency of physical assistance

• Is assistance needed to access the toilet, commode, urinal, etc.?
• What type of prompting is needed to encourage urination?

Environmental Factors/Assistive Devices

Environmental factors and assistive devices

• May restrict or facilitate a resident's ability to access the toilet
  – grab bars
  – raised or low toilet seats
  – inadequate lighting
  – distance to toilet or bedside commodes
  – availability of urinals
  – use of bed rails or restraints
  – fear of falling
Pertinent Diagnoses

Pertinent diagnoses

• CHF
• Stroke
• Diabetes Mellitus
• Obesity
• Neurological disorders (MS, Parkinson’s disease)
• Tumors - could affect the urinary tract or its function

Potential Complications/Testing

• Identification of and/or potential of developing complications such as skin irritation or breakdown.
• Tests or studies indicated to identify the post-void residual for those who have or are at risk for urinary retention
• Urine culture – clinically significant systemic or urinary symptoms
• Evaluations assessing the resident’s readiness for bladder rehabilitation programs
Resident Choice

- Educate to treatment options, outcomes, and consequences.
- They have the right to refuse treatments.

Types of Incontinence

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

- Characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis).
- 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.

Urge Incontinence

- The resident can feel the need to void, but is unable to inhibit voiding long enough to reach and sit on the commode.
- Most common cause of urinary incontinence in elderly persons.
Stress Incontinence

- Loss of a small amount of urine with physical activity such as coughing, sneezing, laughing, walking stairs or lifting.
- Urine leakage results from an increase in intra-abdominal pressure on a bladder that is not over distended.
- Second most common type of urinary incontinence in older women.

Mixed Incontinence

- Combination of urge incontinence and stress incontinence.
- Many elderly persons (especially women) will experience symptoms of both urge and stress called mixed incontinence.
Overflow Incontinence

- Occurs when the bladder is distended from urine retention.
- Symptoms of overflow incontinence may include:
  - weak stream, hesitancy, or intermittency; dysuria; nocturia; frequency; incomplete voiding; frequent or constant dribbling.

Overflow Incontinence

- Urine retention may result from outlet obstruction (e.g., benign prostatic hypertrophy (BPH), prostate cancer, and urethral stricture), hypotonic bladder or both.
- Neurogenic bladder may also result from neurological conditions such as diabetes mellitus, spinal cord injury, or pelvic nerve damage from surgery or radiation therapy.
Overflow Incontinence

- 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 ml may suggest a need for retesting to determine if this finding is clinically significant. Consider use of bladder scanner.
- Overflow incontinence may mimic urge or stress incontinence but is less common than either of those.

Functional Incontinence

- Secondary to factors other than inherently abnormal urinary tract function.
- May 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)
Functional Incontinence

- Environmental impediments (e.g., excessive distance of the resident from the toilet facilities, poor lighting, low chairs that are difficult to get out of, physical restraints and toilets that are difficult to access).

Transient Incontinence

- Temporary or occasional incontinence that may be related to a variety of causes:
  - 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.
Bowel Management Program Components

• Bowel Management program includes but is not limited to the following:
  – Protocols for dietary interventions.
  – Bowel protocols based on bowel movement patterns.

Bowel Assessment

• Bowel Assessment should identify the following:
  – Bowel History i.e. History of constipation, fecal impaction, and bowel regimen.
  – Current pattern-frequency, amount, color, and consistency.
  – Prior history of laxative and enema use.
  – Fluid intake.
Indwelling Catheter

Comprehensive assessment should include:

- Underlying factors supporting the medical justification for the initiation and continuing need for catheter used.

- Determination of which factors can be modified or reversed (or rationale for why those factors should not be modified).

- Consideration of the risks and benefits of an indwelling (suprapubic or urethral) catheter.
Indwelling Catheter

- 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.
- Development of plan to removal unless justification is documented.

Intermittent Catheterization

- Often manages 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 Catheter Use - Justification

Appropriate indications for continuing use of an indwelling catheter beyond 14 days may include:

- Urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible, and which is characterized by:
  - Documented post void residual (PVR) volumes in a range over 200 milliliters (ml);
  - Inability to manage the retention/incontinence with intermittent catheterization; and
  - Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction.

- Contamination of Stage III or IV pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence;

- Terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable, or which is associated with intractable pain.

- Ask physician to provide a diagnosis to support use of indwelling catheter if used.
Types of Incontinence/Diagnosis

• For all other incontinent residents, determine type of incontinence, a collaborative effort with the physician. Recommend a physician’s diagnosis.
  – UNSPECIFIED URINARY INCONTINENCE R32
  – URGE INCONTINENCE N39.41
  – STRESS INCONTINENCE (FEMALE) (MALE) N39.3
  – MIXED INCONTINENCE N39.46
  – INCONTINENCE WITHOUT SENSORY AWARENESS N39.42
  – POST-VOID DРИBBLING N39.43
  – CONTINUOUS LEAKAGE N39.45
  – RETENTION OF URINE, UNSPECIFIED R33.9
  – FREQUENCY OF MICTURITION R35.0

Elimination Plan

• The elimination plan would be one of the following Bladder/Bowel Management programs:
  – Bladder or bowel re-training
  – Habit Voiding/ Scheduled Toileting
  – Prompted Voiding
  – Incontinent Management (Check and Change)
  – Indwelling Catheter
Communication of Elimination Plan

• The health center must have a system to ensure that direct care providers know the elimination plan, including the scheduled/habit/prompted toileting or re-training plan/schedule.

• The communication system could be on aide flow sheet or aide information sheet.

Communication of Elimination Plan

• Options for communicating with direct caregivers:
  – Put individualized scheduled toileting regime on ADL flow sheet as “information only.”
  – Put individualized scheduled toileting regime on ADL flow to chart as “done” each shift.
  – Outline scheduled toileting plan and place information in ADL book or on an aide care plan whether kept in ADL book or hung in room in closet.
Maintenance Plan

- When a resident is not being evaluated using a voiding pattern data gathering system, the resident is on a maintenance plan.
- The health center will have a system for documenting the overall success of the maintenance elimination plan.
- For example, the number of continent or incontinent episodes is documented on the routine ADL forms completed by direct care providers each shift.

Maintenance Plan

- Documentation demonstrates, on an ongoing basis, the success of the toileting plan.
  - Code “Number of Voids” each shift and then the number of “Continent Voids.” For example, voided 3 times in one shift, 1 was continent (the other two were wet).
Catheter Removal

• Initiate procedures for removing indwelling catheter and bladder re-training.
• Resident would be placed on bladder re-training protocols initially with use of re-training tools. Place on “alert charting” for the first 3 days after removal of catheter.
• Initiate re-training form based on overall Bowel and Bladder Risk Tool for documentation by aides.

Catheter Removal

• Place on alert status and document to status every shift during training period of two weeks.
• Provide fluids and toilet every two hours initially.
• Place on Intake and Output.
• Encourage resident to recognize need to void.
• If output is low, perform a Post Void Residual test with a straight catheter or bladder scanner.
• Modify toileting schedule as needed during 2 to 3 week training period.
Indications to Treat a UTI

- Treat only symptomatic UTIs. Symptomatic UTIs are based on the following criteria:
- Residents without a catheter should have at least three of the following signs and symptoms:
  - Fever (increase in temperature of >2 degrees F (1.1 degrees C) or rectal temperature >99.5 degrees F (37.5 degrees C) or single measurement of temperature >100 degrees F (37.8 degrees C))
  - New or increased burning pain on urination, frequency or urgency;
  - New flank or suprapublic pain or tenderness;
  - Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or
  - Worsening of mental or functional status (e.g., confusion, decreased appetite, unexplained falls, incontinence of recent onset, lethargy, decreased activity).
Indications to Treat a UTI/Catheter

- Residents with a catheter should have at least two of the following signs and symptoms:
  - Fever or chills;
  - New flank pain or suprapubic pain or tenderness;
  - Change in character of urine (e.g., new bloody urine, foul smell, or amount of sediment) or as reported by the laboratory (new pyuria or microscopic hematuria); and/or
- Worsening of mental or functional status.
- Local findings such as obstruction, leakage, or mucosal trauma (hematuria) may also be present.
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 routinely necessary but may be useful in select situations.
- Continued bacteriuria without residual symptoms does not warrant repeat or continued antibiotic therapy.

Recurrent UTIs

- 2 or more in 6 months in a non-catheterized 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

- **Steps:**
  - Reassess current toileting plan and fluid needs.
  - Perform PVR or bladder scan.
  - Consider referral to MD or specialist for additional work-up.

Recurrent Symptomatic UTIs with Catheter

- Recurrent symptomatic UTIs in a catheterized individual should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling in accordance with accepted practice for catheter care.
- And to reconsider the relative risks and benefits of continuing the use of an indwelling catheter.
Recurrent Symptomatic UTIs with Catheter

• Steps:
  – Review peri-care procedures with assigned aides to ensure proper technique and consistent removal of fecal soiling in accordance with accepted practice;
  – Employ standard infection control practices in managing catheters and associated drainage system;
  – Strive to 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);
  – Take measures to 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.
Care Plan Protocols

Required Key Components:

• **Bowel and Bladder Programs and Care Plan Protocols**

  • The health center shall develop and utilize Bowel and Bladder toileting programs and care delivery protocols.

  • These care planning protocols will then be individualized for each resident.

• Interventions are implemented based on resident’s assessment:

  • Care plan should include: (can be addressed anywhere on the care plan)

    – Bladder program/toileting plan
    – Any related functional issues
    – Any related adaptive devices used
    – Pain or other related medical problems
    – Hydration needs
Bladder Rehabilitation/Re-Training

- 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 the urge to void.
- Using data gathered from voiding pattern, goal is to delay voiding for a specified amount of time.
- Requires the resident’s cooperation and motivation in order for learning and practice to occur.

Bladder Rehabilitation/Re-Training

- Appropriate for:
  - Cognitively intact residents that usually have experienced incontinence for a short period sometimes related to a medical event.
  - Residents that are motivated and able to learn techniques to resist urge to void.
  - Residents that are fairly independent in ADLs, have occasional incontinence, are aware of the need to urinate, may wear incontinence products for episodic urine leakage, and have a goal to maintain continence and decrease urine leakage.
Bladder Rehabilitation/Re-Training

• May not be successful in the frail, elderly or dependent resident.
• A bladder re-training program will continue as long as progress is being made and the resident has not stabilized; usually to 2 to 3 weeks.
• Care plan is revised as needed and reviewed daily.
• Place resident on alert charting with assessment and progress documented each shift until stable.

• Three components:
  – **Education** – Taught to delay voiding/manage schedule for voiding. Must be able to resist or inhibit the sensation of urgency, to postpone voiding, and to urinate according to timetable versus urge.
  – **Scheduled Voiding** – Toileting intervals initially at 2 or 3 hours except when sleeping. Alter as needed.
  – **Positive reinforcement** – Includes systematic effort to motivate the resident to delay voiding and resist urge.
Care Planning Examples

• Needs Statements:
  – Incontinence as evidenced by:
    • Describe frequency of incontinence (use MDS code definitions)
    • Describe type of incontinence, e.g., Stress, Urge

• Contributing factors:
  – Medical condition (specific)
  – Medication use (specific)
  – ADL needs
  – Motivation

Outcome/Goals:
• Increase the number of continent episodes.
• Resident will achieve bladder stability and/or control.
• Will achieve continence after removal of indwelling catheter.
• Will achieve prior continence status after removal of indwelling catheter.
Care Planning Examples

Interventions:

• Complete re-training pattern forms.
• Encourage resident to delay voiding and attempt to increase time starting at 2 hour intervals. As ability to delay voiding improves plan may change.
• Encourage fluids throughout day and during care and meals with general goal of 1500-2000cc per day modified as needed for resident.

Care Planning Examples

Interventions:

• Limit fluids after 8:00 p.m. if appropriate for resident needs
• How toileted: toilet, commode, urinal, bedpan, raised toilet seat
• Indicate individualized toileting plan for the resident
• Indicate generic scheduled toileting plan
• Peri-care per health center policy (center must develop policies regarding peri-care)
Care Planning Examples

• Call light within reach
• Rise alarm if appropriate
• Mobility status
• List any behaviors that may indicate need to void
• Apply methods as needed to assist with voiding; adequate time, running water, pouring warm water over perineum, gentle pressure on lower abdomen, or hands of resident placed in bowl of water.
• When possible, have male residents stand to void.

Pelvic Floor Muscle Rehabilitation:

• Pelvic Floor/Kegel Exercises if appropriate and motivated.
• Performed to strengthen the voluntary periuretheral 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 Rehabilitation:

- Strengthen the muscular components of urethral supports and are the cornerstone of noninvasive treatment of stress urinary incontinence.
- Pelvic Floor Muscle Exercises (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.

Prompted Voiding Program

- Dependent on staff involvement and assistance, as opposed to resident function.
- Behavioral technique appropriate for use with more cognitively impaired residents that can toilet themselves with only supervision or limited assist.
- Effective in cognitively impaired residents that have some awareness of need to void and an identified voiding pattern.
- Usually works best with urge or mixed incontinence.
Prompted Voiding Program

• Prompted voiding attempts to teach the incontinent person to recognize bladder fullness or need to void, to ask for help, or to respond when prompted to toilet. This includes:
  – Monitoring - The person is checked by caregivers and encouraged to report continence status, asked verbally if wet or dry.
  – Prompting – The person is asked (prompted) to try and use toilet on a scheduled basis.
  – Praising – The person is praised for maintaining continence and for attempting to toilet.

Care Planning Examples

Need Statements:
• Incontinence as evidenced by:
  – Describe frequency of incontinence (use MDS code definitions)
  – Describe type of incontinence, i.e., Urge or mixed Urge

• Contributing Factors:
  – Medical condition (specific)
  – Cognitive loss
  – Functional losses
Care Planning Examples

Outcome/Goals:
• Maintain current continent status with no increase in incontinent episodes.
• Increase the number of continent episodes.
• Achieve continence through scheduled toileting plan during waking hours.
• Achieve continence.
• Achieve continence during day.

Care Planning Examples

Outcome/Goals:
• Experience a decrease in incontinent episodes.
• Will not experience any complications as a result of incontinence.
Care Planning Examples

**Interventions:**

• Initiate voiding pattern form.
• Monitor for signals of need to void.
• List any behaviors that may indicate need to void.
• Prompt to void according to the following times:______________

Care Planning Examples

**Interventions:**

• Prior to or at time of scheduled toileting, staff to ask resident if the resident is wet or dry, and ask resident if they need to void.
• This prompts the residents to toilet themselves or asks for assistance to toilet.
Care Planning Examples

Interventions:
The care plan will reflect the individual toileting schedule. For example, upon rising, 1 hour before meals, within 1 hour after meals, at bedtime.
• Praise all efforts.
• Encourage fluids throughout day and during care and meals with general goal of 1500-2000cc per day modified as needed for resident.
• Limit fluids after 8:00 p.m. if appropriate

---

Interventions:
How toileted: toilet, commode, urinal, bedpan, raised toilet seat
• Rise alarm if appropriate
• Mobility status
• Apply methods as needed to assist with voiding; adequate time, running water, pouring warm water over perineum, gentle pressure on lower abdomen, or hands of resident placed in bowl of water.
• When possible, have male residents stand to void.
Habit Voiding/Scheduled Toileting

- Behavioral technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident’s voiding habits.
- Goal is to keep the resident dry by telling them to void at regular intervals.
- Attempts are made to match the voiding intervals to the resident’s natural voiding pattern.

Habit Voiding/Scheduled Toileting

- Using the information gathered during the voiding pattern data gathering, a scheduled/habit voiding program is put in place.
- Candidates:
  - Residents who cannot toilet self
  - Severely cognitively impaired
  - Frail elderly
Habit Training

- Includes timed voiding with the intervals based on resident’s usual voiding pattern or schedule if one was noted during voiding pattern observation period.
- May or may not include toileting at night.

Scheduled Voiding

- Timed voiding, usually every three to four hours while awake.
- This routine may be scheduled such as before and after meals and at bedtime.
- May or may not include toileting at night.
Care Planning Examples

Needs Statements:

• Incontinence as evidenced by:
  – Describe frequency of incontinence (use MDS code definitions)
  – Describe type of incontinence, e.g., Stress, Urge

Contributing factors:

– Medical condition (specific)
– Medication use (specific)
– ADL needs
– Cognitive loss
Care Planning Examples

Outcome/Goals:
• Maintain current continent status with no increase in incontinent episodes.
• Increase the number of continent episodes.
• Achieve continence through scheduled toileting plan during waking hours.
• Achieve continence.
• Achieve continence during day.

Care Planning Examples

Outcome/Goals:
• Experience a decrease in incontinent episodes.
• Will not experience any complications as a result of incontinence.
Care Planning Examples

Interventions:
- Initiate voiding pattern.
- The care plan will reflect the individual toileting schedule if a pattern is noted. For example, upon rising, 1 hour before meals, within 1 hour after meals, and at bedtime.
- For generic toileting indicate routine e.g. before and after meals and at bedtime.
- Indicate individualized toileting plan specific for the resident.

Interventions:
- Encourage fluids throughout day and during care and meals with general goal of 1500-2000cc per day modified as needed for resident.
- Limit fluids after 8:00PM if appropriate for resident needs.
- How toileted: toilet, commode, urinal, bedpan, and raised toilet seat.
- Rise alarm if appropriate.
Care Planning Examples

**Interventions:**

- Mobility status.
- List any behaviors that may indicate need to void.
- Apply methods as needed to assist with voiding; adequate time, running water, pouring warm water over perineum, gentle pressure on lower abdomen, or hands of resident placed in bowl of water.
- When possible, have male residents stand to void.

Total Incontinence Management

(Check and Change)

- Not all residents are appropriate for habit toileting. Some clinical indicators include:
  - Continuous loss of urine at unpredictable times
  - Total lack of awareness that bladder is filling or full
  - Lack of awareness of incontinence
  - Terminal Illness
  - Pain
Total Incontinence Management (Check and Change)

Not all residents are appropriate for habit toileting. Some clinical indicators include:
  – Significant agitated behaviors
  – Stage 3 or 4 pressure ulcer
  – Very frail elderly
  – Ostomy or indwelling catheter

• Using the information gathered during the voiding pattern data gathering, the decision is made to not place the resident on a Habit/Scheduled Toileting program.
• Instead the facility implements a care plan whereby the resident is checked every 2 hours (or per facility policy and resident risk factors), and cleaned as necessary.
• The health center may use supplies such as adult disposable briefs.
Care Planning Examples

Need Statements:
• At risk for complications resulting from total incontinence:
• Describe frequency of incontinence (use MDS code definitions)
• Describe type of incontinence, e.g., Stress, Urge

Contributing factors:
• Medical condition (specific)
• Medication use (specific)
• ADL needs
• Failed toileting efforts
• Pain
• Terminal
• Coma
Care Planning Examples

Outcome/Goals:
• Will not experience complications resulting from incontinence.
• Will not experience UTIs or skin breakdown due to total incontinence.

Interventions:
• Check resident every two hours (or as appropriate for resident)
• Change and clean resident per health center protocols
• Use incontinence supplies as directed i.e. adult briefs
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.

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.
Bowel Management Program

Bowel Re-training:
• Voiding pattern data collection monitored bowel movements during assessment process.
• Resident is toileted at identified time for defecation.
• If needed, insert suppository 30 minutes prior to anticipated time of defecation.
• Dietary completes an assessment that includes assessment of fluid and fiber needs.

Bowel Management Program

Bowel Re-training:
• Other natural interventions.
• Laxatives and enemas as ordered.
• Nurse monitors progress with a weekly progress note.
Ongoing Bowel Management

- Ongoing documentation - Resident Bowel Movements are documented daily.
- Documentation includes size and consistency.
- Dietary completes an assessment that includes assessment of fluid and fiber needs.
- Other natural interventions.
- Laxatives and enemas as ordered.
- The effectiveness of care plan will be evaluated as needed and at least quarterly.

Ongoing Bowel Management

- A Bowel Regime includes but is not limited to the following:
  - Progressive dietary interventions established by dietary i.e. add fiber, dietary/natural laxatives
  - Stool softeners daily are considered
  - Progressive interventions at 24, 48, and 72 hours without a Bowel Movement
Care Planning Examples

Need Statements:
• Risk of complications from constipation as evidenced by:
  – Describe frequency of incontinence (use MDS code definitions)
  – Describe type of incontinence, e.g., Stress, Urge

Contributing factors:
• Medical condition (specific)
• Medication use (specific)
• ADL needs
• Lifelong problems
• Refusal of dietary interventions
• Poor appetite
Care Planning Examples

**Outcome/Goal:**
- Will experience routine bowel movements
- Will be continent of bowel
- Will have a decrease in episodes of incontinence of bowel
- Will not experience a fecal impaction

**Interventions:**
- Follow facility Bowel Regime procedures
- Indicate usual time for defecation
- How toilet – i.e. commode or bedpan or Check and Change protocols
- Encourage activities and exercise
- Encourage fluids throughout day and during care and meals with general goal of 1500-2000cc per day modified as needed for resident
Care Planning Examples

Interventions:
• Rise alarm if appropriate
• Mobility status
• List any behaviors that may indicate need to defecate

Indwelling Catheter

• Indicate type of catheter and size in physician orders.
• Document changes in catheter on treatment record or in nurse’s notes.
# Care Planning Examples

**Need Statements:**
- Risk of complications from indwelling catheter:

**Contributing factors:**
- Fluid intake
- Fecal contamination
- Mobility

**Outcome/Goal:**
- Will not experience complications due to presence of catheter.

<table>
<thead>
<tr>
<th>Care Planning Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interventions:</strong></td>
</tr>
<tr>
<td>• Catheter care per health center policy.</td>
</tr>
<tr>
<td>• Type and size of catheter.</td>
</tr>
<tr>
<td>• Pericare per center procedures (center must have pericare protocols).</td>
</tr>
<tr>
<td>• Keep catheter bag covered.</td>
</tr>
<tr>
<td>• Monitor output every shift.</td>
</tr>
<tr>
<td>• Encourage fluids with a goal of 1500 to 2000cc.</td>
</tr>
</tbody>
</table>
Care Planning Examples

Interventions:
- Follow appropriate infection control procedures.
- Pericare procedures.
- Secure bag to minimize trauma.
- Secure catheter to facilitate flow of urine.
- Do not break system unless needed to secure a leg bag.
- Change catheter if obstructed.
- Monitor for symptomatic UTI.

Quality Assurance

Required Key Components:
- The QA Committee will establish oversight of Bowel and Bladder Management programs.
- The QA Committee will ensure program aligns with current standards of practice and regulations.
- Medical Director approves program.
Quality Assurance

• The health center will perform routine audits of a sample of residents with any of the following Quality Measures when available:
  • Percent of residents with a urinary tract infection (long stay) (CMS)
  • Percent of low-risk residents who lose control of their bowels or bladder (long stay) (CMS)
  • Percent of residents who have/had a catheter inserted and left in their bladder (long stay) (CMS)

Quality Assurance

• QA Committee uses published standards of practice as resource.
• Ensure adequate adaptive devices are available to care team for use with resident care planning.
• Quality Measures are printed monthly. Review Prevalence of Indwelling Catheters and Prevalence of Low Risk Residents who Lost Control of their Bladder/Bowel and audit using QA/QM Screens.
Quality Assurance

• Trends reported quarterly to QI/QA Committee.
• Trends may include patterns and comparison to established benchmarks.
• Include summary of any improvement efforts in QA minutes.
# Bowel and Bladder Management

## Bowel and Bladder Initial Assessment

<table>
<thead>
<tr>
<th></th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bladder Control</strong></td>
<td>Continent or has indwelling catheter</td>
<td>Continent at least 3xday</td>
<td>Continent 1-2x day</td>
<td>Never Continent</td>
</tr>
<tr>
<td><strong>Bowel Control</strong></td>
<td>Continent more than 4xweek or colostomy</td>
<td>Continent 3-4xweek</td>
<td>Continent 1-2x week</td>
<td>Never Continent</td>
</tr>
<tr>
<td><strong>Can walk to BR or transfer to toilet. Can manage clothes, wipe, urinal</strong></td>
<td>Alone with reasonable speed</td>
<td>Alone but slow</td>
<td>Needs assist from one person</td>
<td>Dependent or needs assist from 2 persons or more</td>
</tr>
<tr>
<td><strong>Mental Status</strong></td>
<td>Alert and oriented</td>
<td>Forgetful but can follow prompts</td>
<td>Confused, needs verbal and physical prompts and assistance</td>
<td>Very confused, combative, refuses to cooperate, depressed</td>
</tr>
<tr>
<td><strong>Mentally aware of toileting needs</strong></td>
<td>Yes, always</td>
<td>Usually</td>
<td>Sometimes</td>
<td>Never</td>
</tr>
<tr>
<td><strong>Condition of skin, genitals, perineal and buttock</strong></td>
<td>No redness</td>
<td>Some redness</td>
<td>Stage 1-2 Pressure Ulcer</td>
<td>Stage 3-4 Pressure Ulcer</td>
</tr>
<tr>
<td><strong>Predisposing Disease (DM, CVA, Prostate Disease, UTIs, Neurogenic Bladder, Retention, Terminal Dx.)</strong></td>
<td>Absent/None</td>
<td>1 risk factor present</td>
<td>2 risk factors present</td>
<td>3 or more risk factors present</td>
</tr>
<tr>
<td><strong>Medications (diuretics, narcotics, sedatives / hypnotics, antidepressants/anti-anxiety, antispasmodics, antihistamines, Calcium channel blockers, antiparkinson’s, antipsychotics, neuromuscular)</strong></td>
<td>None</td>
<td>Yes, taking one of the meds listed</td>
<td>Yes, taking two</td>
<td>Yes, taking three or more</td>
</tr>
</tbody>
</table>

### Potential B&B Retraining:

- 18-24: Retraining potential,
- 10-17: Potential for Habit/Prompted/Scheduled Toileting,
- 0-9: Poor candidate

### Date of Assessment

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### Initial Signature

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</table>

<table>
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<th>NAME: Last</th>
<th>First</th>
<th>Middle</th>
<th>Attending Physician</th>
<th>Record No.</th>
<th>Room/Bed</th>
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</thead>
</table>

FH37 - Developed by Polaris Group  www.polaris-group.com  Page 77 of 89
<table>
<thead>
<tr>
<th>1. INITIAL/QUARTERLY ELIMINATION ASSESSMENT SUMMARY</th>
<th>2. QUARTERLY ELIMINATION ASSESSMENT SUMMARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of risk factors, environmental. Functional/adaptive device needs, &amp; voiding pattern data: Bladder Risk Score: _____</td>
<td>Summary of risk factors, environmental. Functional/adaptive device needs, &amp; voiding pattern data: Bladder Risk Score: _____</td>
</tr>
<tr>
<td>Type of Incontinence: ☐ Urge ☐ Stress ☐ Mix ☐ Overflow ☐ Functional ☐ Other ☐ Unknown</td>
<td>Type of Incontinence: ☐ Urge ☐ Stress ☐ Mix ☐ Overflow ☐ Functional ☐ Other ☐ Unknown</td>
</tr>
<tr>
<td>☐ Implement Bladder or Bowel retraining program:</td>
<td>☐ Implement Bladder or Bowel retraining program:</td>
</tr>
<tr>
<td>☐ Implement Intermittent Catheterization:</td>
<td>☐ Implement Intermittent Catheterization:</td>
</tr>
<tr>
<td>Implement: ☐ Prompted ☐ Habit ☐ Scheduled toileting plan: ☐ Bladder ☐ Bowel ☐ Both Prior failed attempts at toileting schedules, ☐ implement Check and Change</td>
<td>Implement: ☐ Prompted ☐ Habit ☐ Scheduled toileting plan: ☐ Bladder ☐ Bowel ☐ Both Prior failed attempts at toileting schedules, ☐ implement Check and Change</td>
</tr>
<tr>
<td>Describe plan:</td>
<td>Describe plan:</td>
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<tr>
<td>☐ Remove ☐ Continue with Indwelling Catheter</td>
<td>☐ Remove ☐ Continue with Indwelling Catheter</td>
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<td>Diagnosis:</td>
<td>Diagnosis:</td>
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<tr>
<td>☐ Infection Control precautions in place:</td>
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<tr>
<td>☐ Special Fluid needs:</td>
<td>☐ Special Fluid needs:</td>
</tr>
<tr>
<td>☐ Care Plan revised/updated/current</td>
<td>☐ Care Plan revised/updated/current</td>
</tr>
<tr>
<td>Assessment completed: ____________________ Date ______</td>
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NAME: Last                                               First                                                       Middle MR#
# Bowel and Bladder Management

## 3-DAY BOWEL AND/OR BLADDER OBSERVATION

<table>
<thead>
<tr>
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<th>1st day</th>
<th>2nd day</th>
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<tbody>
<tr>
<td></td>
<td>BOWEL</td>
<td>BLADDER</td>
<td>BOWEL</td>
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</tbody>
</table>

### PLAN OF ACTION:

CIRCLE which applies

1. Check Q 1 hr. night or day
2. Toilet Q 2 hrs. while awake
3. Offer fluids Q 2 hrs.
4. Toilet upon rising
5. Toilet after meals
6. Toilet before meals
7. Toilet at bedtime
8. Toilet during night at ___ intervals
9. Other ____________

### Observation

**Codes:**
- UI – Incontinent of urine
- C – Found clean and dry
- BI – Incontinent of bowel
- V – Voided successfully
- T – Toileted self/continent
- S – Assisted to toilet with result
- W – Assisted to toilet without result
- R – Resident refused/uncoop.

### Ratio of UI/BI to Dry/Voids

- # OF TIMES UI or BI
- # OF TIMES DRY/VOID

If the # of Dry/Voids is the same or less than # Wets/Soiled, then continue data collection for another 3 days to have more data.

If the # of Dry/Voids is the greater than # of Wets/Soiled, use pattern to develop habit/scheduled toileting plan.

If the # of Dry/Voids is less than 15% when compared to the # of Wets/Soiled, collect more data or consider Check and Change.

**RESIDENT:** ____________________________ **MED REC#** ____________________ **ROOM NO:** _________________
Bowel and Bladder Management

CONTINENCE & CATHETER ASSESSMENT

FACTORS POTENTIALLY related to CONTINENCE STATUS

Bowel and Bladder Risk Score: _______________________
(Complete as part of RAI process and after Voiding Pattern Data Collection has occurred)

<table>
<thead>
<tr>
<th>Current DIAGNOSES</th>
<th>Indicate MEDICATIONS currently taking:</th>
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</thead>
<tbody>
<tr>
<td>Admit date:</td>
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<tr>
<td>History of:</td>
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<tr>
<td>☐ Urinary disorders</td>
<td>☐ Bladder disorders</td>
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</tr>
<tr>
<td></td>
<td>☐ Drugs that stimulate or</td>
</tr>
<tr>
<td></td>
<td>block sympathetic nervous system</td>
</tr>
</tbody>
</table>

☐ No impairments impacting ability to toilet
☐ Impaired physical ability to use:
  ☐ toilet
  ☐ commode
  ☐ bedpan/urinal
  ☐ call light
  Due to decline in:
  ☐ ROM
  ☐ Fx
  ☐ lighting
  ☐ transferability
  ☐ cast
  ☐ difficulty removing clothes
  ☐ bed mobility
  ☐ need for adaptive device

☐ Impaired cognitive ability to use:
  ☐ toilet
  ☐ commode
  ☐ bedpan/urinal
  ☐ call light
  Due to decline in:
  ☐ impaired memory
  ☐ comatose
  ☐ resistive to care
  ☐ refusal of care
  ☐ inability to remember toileting tasks

☐ Impaired sensory ability to use:
  ☐ toilet
  ☐ commode
  ☐ bedpan/urinal
  ☐ call light
  Due to decline in:
  ☐ vision
  ☐ blind
  ☐ hearing
  ☐ aphasic
  ☐ decline in communication skills

☐ Environmental factors:
  ☐ location of toilet
  ☐ lighting
  ☐ location of commode

☐ See RD Assessment regarding diet, fiber, fluid needs.

BOWEL ASSESSMENT

(Complete at end of 3-day observation period)

CONTINENT of STOOL: ☐ Yes ☐ No
If incontinent: How long has resident been incontinent?
  ☐ Days ☐ Months ☐ Years
Reason identified, if known:

Frequency of incontinence:
☐ Less than weekly ☐ Once a week ☐ 2-3 times a week
☐ All (or almost all) the time

USUAL ELIMINATION PATTERN:
Frequency:
Time(s) of Day:
  ☐ Upon rising
  ☐ After meal(s): ☐ Bkfst ☐ Lunch ☐ Dinner
  ☐ No apparent pattern
  ☐ Other (describe):

Amount: ☐ Small ☐ Med. ☐ Large ☐ Other:
Perception of need to evacuate: ☐ Present ☐ Diminished ☐ Absent
Prompting method:

History of impactions: ☐ No ☐ Yes, freq: ____________%

Results of 3-day Observation: ____________ % Continent
Pattern: ____________

USUAL CONSISTENCY:
  Consistency: ☐ Hard ☐ Formed ☐ Soft ☐ Liquid ☐ Other: ____________
  Color: ☐ Tarry ☐ Light/Medium ☐ Dark Brown ☐ Clay ☐ Other: ____________
Flatulence:
  ☐ If known, caused by: ____________
  ☐ Other (describe): ____________
Comments:

ADDITIONAL PHYSICAL SYMPTOMS/PROBLEMS:
  ☐ Bowel Sounds:
  ☐ Comments:

ELIMINATION ASSISTS:
  ☐ None used
  ☐ Stool softeners, name, dose, freq: ____________
  ☐ Laxatives, name, dose, freq: ____________
  ☐ Enemas, type, amount, freq: ____________
  ☐ Suppositories, type, amount, freq: ____________
  ☐ Juice/Fiber, type, freq: ____________
  ☐ Comments:

EXERCISE PATTERNS:
  Describe usual daily activities:
  Is resident capable of increasing? ☐ Yes ☐ No, describe:
  ☐ Comments:

Resident # ________  ID# ________  Room # ________  Physician ________

FH37 - Developed by Polaris Group  www.polaris-group.com  Page 80 of 89
## BLADDER ASSESSMENT

### CONTINENT of URINE:
- [ ] Yes
- [ ] No

If incontinent: How long has resident been incontinent?
- [ ] Days
- [ ] Months
- [ ] Years

Reason identified, if known:

Frequency of incontinence:
- [ ] Once a week or less
- [ ] 2 or more times a week, not daily
- [ ] Daily, with some control
- [ ] Multiple daily episodes

### USUAL VOIDING PATTERN: Based on 3-day observation:

#### % continent

Frequency:

Time(s) of Day:
- [ ] Upon rising
- [ ] After meals: [ ] At bedtime
- [ ] During the night
- [ ] No apparent pattern
- [ ] Other (describe):

Perception of need to urinate:
- [ ] Present
- [ ] Diminished
- [ ] Absent

Post-voiding perception:
- [ ] Complete emptying
- [ ] Continued desire to void

### URINE:

#### Color:
- [ ] Resident is on meds that could affect color:

#### Clarity:

#### Odor:

Date of last urinalysis:

Results:

Comments:

Burning:

### VOIDING SYMPTOMS/PROBLEMS:

- [ ] Dribbles
- [ ] Stress
- [ ] Urge
- [ ] Unknown
- [ ] Overflow
- [ ] Functional
- [ ] Mix
- [ ] Other

- [ ] Indwelling catheter
  - Justification:

- [ ] Suprapubic
- [ ] Ureterostomy
- [ ] Straight catheter

### Post-void Residual, if indicated:

- [ ] Bladder distention upon palpation immediately post-voiding

Time elapsed from voiding:

Bladder emptied by external stimuli:
- [ ] Kegel exercise
- [ ] Warm water over perineum
- [ ] Catheter
- [ ] Other

Bladder Scan uses:
- [ ] Yes
- [ ] No

Amount of urine: ________ cc

### SUMMARY OF RETRAINING POTENTIAL

Summary of risk factors, environmental. Functional/adaptive device needs, & voiding pattern data:

- [ ] Implement Bladder or Bowel retraining program:

- [ ] Implement Intermittent Catheterization:
  - [ ] Prompted
  - [ ] Habit

- [ ] Scheduled toileting training program as the individualization scheduled toileting plan for:
  - [ ] Bladder
  - [ ] Bowel
  - OR

- [ ] Prior failed attempts at toileting schedules, implement Check and Change

Describe toileting plan:

- [ ] Remove
- [ ] Continue with Foley Catheter
  - Justification:

- [ ] Infection Control in place:

- [ ] Fluid needs:

- [ ] Care Plan Completed

Assessment completed by: ____________________________ Date: ________________

Resident # ID# Room # Physician

FH37 - Developed by Polaris Group  www.polaris-group.com
# Bowel and Bladder Management

## FOLEY CATHETER ASSESSMENT AND MANAGEMENT

A resident is not to be catheterized unless his/her clinical condition demonstrated that catheterization was necessary. An indwelling catheter should only be used when there is a **valid medical justification**. In order to assess the need for catheterization the following questions need to be answered:

<table>
<thead>
<tr>
<th>Question</th>
<th>Y (Yes)</th>
<th>N (No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the resident have a valid medical justification (supporting diagnosis) for use of the indwelling catheter?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>List: ____________________________________________________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the resident have documented urinary retention that cannot be treated or corrected medically or surgically, for which alternative therapy is not feasible characterized by:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Documented post void residual (PVR) volumes in a range over 200ml.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Inability to manage the retention/incontinence with intermittent catherization; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Persistent overflow incontinence, symptomatic infections, and/or renal dysfunction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the resident have supporting diagnostic testing or unsuccessful catheter-free trials documented?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the resident have contamination of Stage 3 or 4 pressure ulcer with urine which has impeded healing, despite appropriate personal care for the incontinence?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the resident have a terminal illness or severe impairment, which makes positioning or clothing changes uncomfortable or which is associated with intractable pain?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If any of the above questions in this section are answered “yes”, then indwelling catheterization may be medically necessary if benefits outweigh risks. Re-evaluation should occur at least quarterly or at time of a symptomatic UTI.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Catheter size: _____</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Check the following practices:

<table>
<thead>
<tr>
<th>Practice</th>
<th>Y (Yes)</th>
<th>N (No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the staff following the facility’s protocol and/or written procedures for catheterization?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do all personnel wash their hands before and after caring for the catheter/tubing/collecting bag?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is staff securing catheter to minimize injury and positioning bag to decrease risk of infection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is staff cleaning the catheter and providing bowel care per protocol?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluid Needs addressed and met?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SUMMARY:

- [ ] Remove catheter and initiate bladder program
- [ ] Continue indwelling catheter

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

RESIDENT: ___________________________ ROOM: __________

SIGNATURE: ______________________ DATE: __________
Bowel and Bladder Management

RESIDENT VOIDING PATTERN & HABIT/SCHEDULED TOILETING PLAN

Goal: Circle One: Continent 100% of the time________.  
Continent during waking hours________. Occasionally incontinent (<3x in 24 hrs)____.

IU= INCONTINENT URINE (Wet) (IB=Inc. Bowel)  CU= CONTINENT URINE (CB=Cont. Bowel)  D=Dry

CODE FOR EACH HOUR TO MEASURE SUCCESS OF PLAN

| Date | 12 M | 1 am | 2 am | 3 am | 4 am | 5 am | 6 am | 7 am | 8 am | 9 am | 10 am | 11 am | Noon | 1 pm | 2 pm | 3 pm | 4 pm | 5 pm | 6 pm | 7 pm | 8 pm | 9 pm | 10 pm | 11 pm |
|------|------|------|------|------|------|------|------|------|------|------|-------|-------|------|------|------|------|------|------|------|------|------|-------|------|

Instructions: Resident is to be toileted =

_______ Upon Arising ________ Before Meals ________ After Meals ________ At Bedtime ________ During the night at ________ Intervals

_______ Toileting every two hours while awake _______ Toileting every one hour while awake

Other (specify times)

Devises Used (D-Day, E-Eve. N-Night): ____Commode at bedside ___ urinal ___ bedpan ___ toilet ___ Other ________________________________

Other directions: _____________________________________________________________________________________________________

RESIDENT NAME: __________________________ DOCTOR: ____________________ ROOM#: ____________
### Bowel and Bladder Risk Assessment

<table>
<thead>
<tr>
<th></th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bladder Control</strong></td>
<td>Continent or has indwelling catheter</td>
<td>Continent at least 3xday</td>
<td>Continent 1-2x day</td>
<td>Never Continent</td>
<td>2</td>
</tr>
<tr>
<td><strong>Bowel Control</strong></td>
<td>Continent more than 4xweek or colostomy</td>
<td>Continent 3-4xweek</td>
<td>Continent 1-2x week</td>
<td>Never Continent</td>
<td>3</td>
</tr>
<tr>
<td>Can walk to BR or transfer to toilet. Can manage clothes, wipe, urinal</td>
<td>Alone with reasonable speed</td>
<td>Alone but slow</td>
<td>Needs assist from one person</td>
<td>Dependent or needs assist from 2 persons or more</td>
<td>1</td>
</tr>
<tr>
<td><strong>Mental Status</strong></td>
<td>Alert and oriented</td>
<td>Forgetful but can follow prompts</td>
<td>Confused, needs verbal and physical prompts and assistance</td>
<td>Very confused, combative, refuses to cooperate, depressed</td>
<td>1</td>
</tr>
<tr>
<td>Mentally aware of toileting needs</td>
<td>Yes, always</td>
<td>Usually</td>
<td>Sometimes</td>
<td>Never</td>
<td>2</td>
</tr>
<tr>
<td>Condition of skin, genitals, perineal and buttock</td>
<td>No redness</td>
<td>Some redness</td>
<td>Stage 1-2 pressure Ulcer</td>
<td>Stage 3-4 Pressure Ulcer</td>
<td>3</td>
</tr>
<tr>
<td>Predisposing Disease (DM, CVA, Prostate Disease, UTIs, Neurogenic Bladder, Retention, Terminal)</td>
<td>Absent</td>
<td>Minor</td>
<td>Moderate</td>
<td>Severe</td>
<td>2</td>
</tr>
<tr>
<td>Medications (diuretics, narcotics, sedatives/hypnotics, antidepressants/antianxiety, antispasmodics, antihistamines, Calcium channel blockers, antiparkinson’s, antipsychotics, neuromuscular)</td>
<td>None</td>
<td>Yes, taking one of the meds listed</td>
<td>Yes, taking two</td>
<td>Yes, taking three or more</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total** 17

**Date**

**Signature**

---

**Potential B&B Retraining:**
- 18-24: Retraining potential,
- 10-17: Potential for Habit/Prompted/Scheduled Toileting,
- 0-9: Poor candidate

**Comments**

**RESIDENT: ____________________________ MED REC# ________________**
Bowel and Bladder Management

## ELIMINATION ASSESSMENT SUMMARY

Score of 17 indicates potential for improved continence. Appears to have some urgency and calls out for help. Appears to empty bladder based on bladder scan results with 40cc residual. Resident requires full assistance of one to toilet whether bedpan or toilet secondary to an old CVA. Between voidings the resident occasionally has stress incontinence. The pattern of voiding is predictable at about every two hours upon rising and bedtime. She sleeps thru the night but then needs to void during 6am rounds. She has a regular BM every other day. She drinks fluids well with meals and likes fluids during activities. She will take sips of water when encouraged.

**Type of Incontinence:**
- Urge: ___
- Stress: ___
- Mix: X
- Overflow: ___
- Functional: ___
- Other: ___
- Unknown: ___

- Implement Bladder or Bowel retraining program:
- Implement Intermittent Catheterization:
- Implement [] Prompted [] Habit [X] Scheduled toileting training program as the individualization scheduled toileting plan for:
  - X Bladder
  - Bowel
  - OR
  - Prior failed attempts at toileting schedules, implement Check and Change

**Describe toileting plan:**
Toilet upon waking up 6am, then check every two hours and immediately if the resident calls out. Toilet prior to nap and bedtime. Do not wake up at night to toilet. The resident will wake up on own.

- Remove
- Continue with Foley Catheter Justification:
- Infection Control in place:
- Fluid needs: Encourage fluids during care.
- Care Plan Completed

**Assessment completed by:** Bridget Jones, RN
**Date:** Jan 1, 20XX

## Example Care Plan:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Date</th>
<th>Interventions</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1, 20XX</td>
<td>Episodes of Incontinence</td>
<td>Will not experience more than 3 episodes of incontinence per week</td>
<td>April 1, 20XX</td>
<td>• Encourage fluids during care.</td>
</tr>
<tr>
<td></td>
<td>Contributing factors:</td>
<td></td>
<td></td>
<td>• Likes room temperature water.</td>
</tr>
<tr>
<td></td>
<td>• Requires assistance with toileting of one person</td>
<td></td>
<td></td>
<td>• When resident calls out, immediately toilet</td>
</tr>
<tr>
<td></td>
<td>• Urge incontinence</td>
<td></td>
<td></td>
<td>• Encourage to use call light.</td>
</tr>
<tr>
<td></td>
<td>• Knows when needs to void</td>
<td></td>
<td></td>
<td>• Toilet on bedpan if in bed.</td>
</tr>
<tr>
<td></td>
<td>• Stress incontinence</td>
<td></td>
<td></td>
<td>• When up use toilet.</td>
</tr>
<tr>
<td></td>
<td>• Takes fluids with encouragement</td>
<td></td>
<td></td>
<td>• Toilet at 6am or when wakes up, every 3 hours, before nap and at bedtime</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Do not wake up at night.</td>
</tr>
</tbody>
</table>
## Bowel and Bladder Management

### Potential B&B Retraining:
- **20-24:** Retraining potential,
- **10-17:** Potential for Habit/Prompted/Scheduled Toileting,
- **0-9:** Poor candidate

### Bowel and Bladder Risk Tool

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<td></td>
</tr>
<tr>
<td>None</td>
<td>2</td>
</tr>
<tr>
<td>Yes, taking one of the meds listed</td>
<td>1</td>
</tr>
<tr>
<td>Yes, taking two or more</td>
<td>0</td>
</tr>
<tr>
<td>Yes, taking three or more</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total:** 15

### Comments

**RESIDENT:** ___________________________  **MED REC#** _____________
**Bowel and Bladder Management**

### Example Care Plan:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Date</th>
<th>Interventions</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan. 1, 20XX</td>
<td>Will void when prompted.</td>
<td>April 1, 20XX</td>
<td>• Encourage fluids during care.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Episodes of Incontinence</td>
<td></td>
<td></td>
<td>• Watch for signs of needing to void.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Contributing factors:</td>
<td></td>
<td></td>
<td>• Prompt to void every even hours while awake and just prior to bedtime around</td>
<td>1/1/XX</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>9pm.</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td></td>
<td></td>
<td>• Praise when voided.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Ambulatory</td>
<td></td>
<td></td>
<td>• Keep urinal at bedside</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Forgets to void</td>
<td></td>
<td></td>
<td>• Dress in loose clothes so can toilet self.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Paces when needs to void</td>
<td></td>
<td></td>
<td>• Do not wake up at night, use adult briefs.</td>
<td>1/1/XX</td>
</tr>
<tr>
<td>Can be combative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**QA SCREEN**

**MDS 3.0 Measure**

# 0685 Low Risk Residents Who Lost Control of Their Bowels or Bladder

**Threshold = 90% or greater**

**Directions:** Audit 50% of residents with Low Risk Residents Who Lost Control of Their Bowels or Bladder if flagged at the 75th % or greater.

*Y or X = Met  NA = Not Applicable*

<table>
<thead>
<tr>
<th>Criteria/Questions</th>
<th>Medical Record/Room Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MDS items that trigger QM/QI and risk level are accurate for observation period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Bowel and Bladder Assessment (CAA) upon admission, quarterly, and at time of change in incontinence status.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Bladder and bowel patterns collected for three days upon admission and at time of decline in continence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Fluid pattern monitoring (i.e. during meals, between meals) documented in the record.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Toileting plan documented: 1) Bladder/Bowel Retraining, 2) Scheduled Toileting (prompted voiding, habit training/ scheduled voiding) check every hour and toileting every two hours during the day and every 4 hours during the night and early AM upon rising, 3) Attends/diapers only, and 4) Indwelling Catheter.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Care plan addresses elimination and interventions, type of incontinence (preferably physician diagnosis), bladder management behavior program, etc. to minimize episodes of incontinence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Care plan addresses fluid needs and bowel routine as indicated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Care plan includes protocols for each type of Behavior Program, incontinence care and is available to staff.</td>
<td></td>
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<tr>
<td>9. Care plan should address Bladder Training Program, Functional Issues, Devises to be used, Pain or other medical issues, Hydration needs etc.</td>
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<tr>
<td>10. Observe provision of care; resident toileted according to care plan, infection control practices followed.</td>
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<tr>
<td>11. If no toileting plan in place, justification is documented: 1) Terminal/ End-Stage Disease, 2) Pain, and 3) Stage 4 Pressure Sore.</td>
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</tr>
<tr>
<td>12. Pharmacy Drug Regimen identifies any risk medications with recommendations.</td>
<td></td>
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</tr>
</tbody>
</table>

**SYSTEM:** QMs printed out monthly; review and investigate if flagged at the 75th % or greater.

---

**Percentage of Compliance = # of Yes responses x100**

**Assessor:**

**Total # of blocks: (# of audits x’s the # of questions-exclude System and NA questions)**

**Threshold Reached:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
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</tbody>
</table>

**Percentage of Compliance ( # yes divided by # blocks = % compliance)**

**Completed By:**

**Title:**

**Date:**
Threshold = 90% or greater

Directions: Audit 100% of Residents Who Have/Had a Catheter Inserted and Left in Their Bladder if flagged at the 75th % or greater.

Y or X = Met
NA = Not Applicable

<table>
<thead>
<tr>
<th>Criteria/Questions</th>
<th>Medical Record/Room Number</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MDS items that trigger QM and risk status are accurate for observation period.</td>
<td></td>
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<tr>
<td>(H0100A =1)</td>
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<tr>
<td>2. Bowel and Bladder Assessment (CAA) upon admission, quarterly, and at time of</td>
<td></td>
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<tr>
<td>change.</td>
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<tr>
<td>3. Physician Order and Diagnosis for Indwelling catheter in the Medical Record:</td>
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<tr>
<td>4. Fluid pattern monitoring (i.e. during meals, between meals) documented in the</td>
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<tr>
<td>record.</td>
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<tr>
<td>5. Care plan addresses fluid needs and bowel routine as indicated.</td>
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<tr>
<td>6. Care Plan addresses catheter care per facility policy.</td>
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<tr>
<td>7. Observe provision of catheter care; infection control practices followed during</td>
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<tr>
<td>care.</td>
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<tr>
<td>8. Positioning of catheter in bed or chair maintains infection control best</td>
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<tr>
<td>practices.</td>
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<tr>
<td>9. Catheter and bag are covered to protect privacy per facility policy.</td>
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<tr>
<td>10. Indwelling Catheter: Documentation supports continued use of indwelling</td>
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</tr>
<tr>
<td>catheter. An indwelling catheter must be justified per regulations F315:</td>
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<tr>
<td>1. Urinary Retention that: a) is causing persistent overflow incontinence,</td>
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<td>symptomatic infections, and/or renal dysfunction, b) Cannot be corrected</td>
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<tr>
<td>surgically, and c) Cannot be managed practically with intermittent catheter use.</td>
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<tr>
<td>2. Skin wounds, pressure sores or irritations that are being contaminated by</td>
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<tr>
<td>urine.</td>
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<tr>
<td>3. Terminal illness or severe impairment, which makes bed and clothing changes</td>
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<tr>
<td>uncomfortable or disruptive.</td>
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</tbody>
</table>

SYSTEM: QM printed out monthly, review and investigate if flagged at the 75th % or greater.

Percentage of Compliance = # of Yes responses x100  
Assessor: 

Total # of blocks: the # of audits x’s the # of questions-exclude System and NA questions)  
Threshold Reached: Yes  No

Percentage of Compliance (# yes divided by # blocks = % compliance)  
Completed By:  
Title:  
Date:  

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