CMS Guidelines and Improving Continence Care in Nursing Homes: The Role of the Medical Director

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Urinary incontinence (UI) has long been one of the most common problems suffered by nursing home (NH) residents. Despite this, little progress has been made in its treatment. On the contrary, the prevalence of UI in NH residents increased from 55% to 65% between 1987 and 1997, despite evidence that UI is one of the most treatable geriatric conditions.1

Most residents with UI cannot toilet without assistance. Hence, a toileting assistance program is essential to their care. UI frequency can in fact be reduced in most residents with the implementation of toileting assistance programs.2 Reasons why this noninvasive and obvious intervention is not implemented range from low staffing levels to the failure of the regulatory system to enforce better incontinence care standards.3 In many ways, the high prevalence of UI is symbolic of system-wide failures to address reversible quality problems in long-term care.

Two new initiatives address barriers to improving incontinence care. These are the Center for Medicare and Medicaid Services’ (CMS’s) new interpretive guidelines for incontinence and for the role of the medical director in ensuring quality of care (Tags F315 & F501). Both guidelines, coupled with other improvements to the survey process that are under consideration by CMS, could increase awareness about the quality of incontinence care in NHs.4,5 Problems with this care process have been the focus of papers and editorials by several authors who have worked in this area.6,7

We believe that the medical director is in an excellent position to improve the quality of incontinence assessment and the treatment plans developed based on these assessments. In this editorial, we recommend action that medical directors can take to serve as agents of change and initiate the process of improving incontinence care. Our immediate recommendations do not follow all the steps presented in incontinence care practice guidelines, although we recognize the importance of implementing these guidelines. Instead, we put forth a simplified approach that we believe is feasible to implement and will increase awareness about the importance of toileting assistance interventions.

Specifically, we suggest that medical directors act to improve the specificity of treatment orders with respect to two key assessments—responsiveness to and preferences for toileting assistance. Standard treatment orders should specify that, in addition to appropriate basic evaluations for potentially remediable contributors to UI, all newly incontinent or newly admitted incontinent residents receive a 2- to 3-day trial of toileting assistance, and that their response to and preference for toileting assistance should be documented at the end of this trial. Exceptions might include residents who are terminally ill, severely behaviorally disturbed, or who have severe musculoskeletal disorders that make toileting painful. In such residents, supportive management may be more appropriate than a toileting assistance program.

The order for a trial of toileting assistance should be accompanied by a policy and procedure that specifies that a simple count of incontinence frequency (eg, “incontinent × 5”) is insufficient for determining a resident’s responsiveness to toileting assistance and his or her preference for incontinence care. Regrettably, this type of documentation is typical of what was found in charts reviewed in more than 17 NHs. Documentation that could be considered an evaluation of a resident’s response to a toileting assistance protocol was noted in less than 2% of records.8 The medical order and/or related policy and procedure should state clearly that a resident should be offered toileting assistance on a 24-hour basis from the time they awaken in the morning until the time they go to bed with the intention of sleeping at night. Prompted voiding and other toileting assistance programs do not work well at night, and can be very disruptive to sleep. UI care at night should be individualized based on the bather to the resident and the risk of falls and skin breakdown.9,10 The response to these offers to toilet should be documented. Specifically, the number of times a resident responds affirmatively to an assistance offer, and the number of times he or she successfully toilets is important information needed to supplement an incontinence frequency count.

A simple rule can be used to select residents for ongoing maintenance on a toileting program: residents who void in the toilet on more than two thirds of all voids during the 2- to 3-day trial can be expected to maintain a high degree of continence when toileting assistance is provided consistently.11 Between 20% and 40% of all incontinent residents...
would be on toileting assistance programs if assessments were done correctly and this rule followed.

In addition to assessing responsiveness to toileting assistance, at the end of the 2- to 3-day trial, staff should document a resident’s response to the question, “How many times a day would you like to be assisted to the toilet?” The answer to this question can help guide an individualized UI care plan that meets the resident’s needs.

Standardized reporting forms that facilitate documentation of a resident’s response to the toileting trial and his or her preference for incontinence care can be downloaded from the UCLA Borun Center’s Web-site at http://borun.medsch.ucla.edu.10

The medical director’s role in ensuring that specific orders for toileting assessment are written is consistent with new interpretative guidelines, which specify that the medical director should coordinate medical care. In addition, a successful toileting assistance program can serve as the basis for a continuous quality improvement program designed to maintain continence.12 Such programs have been proven effective in several NH settings, and should be considered by medical directors for implementation in their facilities.13,14

Even if better orders are written, it is still questionable whether they will be followed, for staffing limitations, lack of adequate supervision of a UI program, and focus on quality improvement in areas perceived as more important in terms of risk and liability (eg, fall, pressure ulcers, polypharmacy) may undermine them. Nevertheless, more specific orders related to UI assessment and care should at least increase awareness of what should be done, and in this regard, they would represent a major improvement in the current state of incontinence care quality.

REFERENCES


