



Oklahoma State
Department of Health
Creating a State of Health

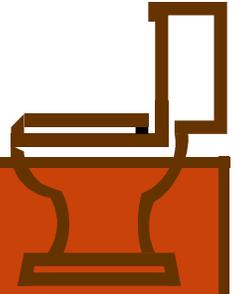
NEWS YOU CAN USE

Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278
Nancy Atkinson, Chief

MDS

Special points of interest:

- A Season of Losses—Contenance—Section H1—The Assessment Process
- MDS Accuracy Quick Check—Section H1—Contenance
- The MDS Connection—Section H1—Contenance
- Automation Tips, Reminders & Updates



A Season of Losses Contenance in the Last 14 Days Section H1—The Assessment Process

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As we watch the season's change and see the falling leaves, we are reminded of the losses around us, i.e., the long days of summer, the green landscape, and the brilliant colors of flowers. Just as losses occur in the seasons, they also occur in our lives and health. One loss that has been said is a primary reason for entering a nursing home is incontinence. Urinary incontinence is the inability to control urination in a socially appropriate manner. Nationally, approximately 50% of nursing facility residents

are incontinent. Since incontinence causes so many problems, including skin rashes, falls, isolation, pressure ulcers, and the poten-

tially troubling use of indwelling catheters, this will be the focus of this issue.

The **INTENT** of H1 is to determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

The **DEFINITION** of H1a (bowel continence) and H1b (bladder continence), refers to control of bowel movement and/or urinary bladder function. This item describes the resident's bowel and bladder continence pattern even with
(Continued on page 2)



GOAL
Highest Practicable
Level of Functioning

MDS Accuracy Quick Check—Section H1

If MDS Item is:

H1b = 0

- Do staff understand the definition of "incontinence"? Do they know even a small volume of urine, for example, due to stress incontinence, should be counted as an incontinent episode?
- Do staff know daily communication between nurses, CNAs, and other direct care providers across all shifts is crucial for resident monitoring and care giving in this area? Staff who work most closely

with residents will know how often residents are dry or wet.

H1a or H1b = 1

- Do staff know any episode of incontinence should be reported and requires intervention not just in terms of immediate incontinence care, but also in terms of dealing with the underlying problem whenever possible, and instituting a re-training, toileting or incontinence care program?

Reference: RAI Manual, Chapter 3, Page 120

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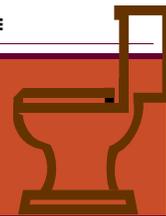
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A Season of Losses—Continence

Section H1—The Assessment Process *(Continued from page 1)*



Incontinence is not a matter of volume but a matter of wetness and irritation and risk for skin breakdown

scheduled toileting plans, continence training programs, or appliances. **It does not refer to the resident's ability to toilet self**—e.g., a resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help.

The **PROCESS** of assessment is to review the resident's clinical record and any bowel elimination or urinary flow sheets (if available). **Validate** the accuracy of written records with the resident. Make sure your discussions are held in private. Control of bowel and/or bladder function are sensitive subjects, particularly for residents who are struggling to maintain control. The **KEY issue** to understand in determining whether or not a resident is incontinent is—**incontinence is not a matter of**

volume. It is a matter of skin wetness and irritation, and the associated risk for skin breakdown.

Coding continence issues is based on a five-point coding scale to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bowel and bladder. The reason for these differences is that there are more episodes of urination per day and week, whereas bowel movements typically occur less often.

The following scales are used as a



Many people with poor bladder control will try to hide it.

basis for the **CODING** decision: **0 = Continent**—refers to complete control (including control achieved by care that involves prompted voiding, habit training, reminders, etc.); **1 = Usually Continent**—refers to bladder incontinent episodes that occur once a week or less and bowel incontinent episodes that occur less than once a week; **2 = Occasionally Incontinent**—refers to bladder incontinent episodes that occur two or more times a week but not daily and bowel incontinent episodes that occur once a week. **3 = Frequently Incontinent**—refers to bladder incontinent episodes that tend to occur daily, but some control is present (e.g., on day shift), and bowel incontinent episodes that occur two or

(Continued on page 3)



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The MDS Connection

Section H1a & H1b—Continence in the Last 14 Days



If H1b = 1, 2, 3, 4

Then review these MDS items:

- **O4a-d**

Many medications can affect the bladder or urethra and result in incontinence. Physicians would usually discontinue suspect medication if possible, weighing the risks and benefits of doing so. For instance, where a calcium channel blocker is used for mild hypertension, another medication might be easily substituted; a medication for arrhythmia, however, might not have an appropriate substitute. Review all medications

regularly prescribed, occasional or “PRN”, and any non-prescribed (“over-the-counter”) medications. Medications that can affect continence include the following classes and types of drugs: any drug with anticholinergic properties, calcium channel blockers, and drugs that affect the sympathetic nervous system.

If H1a or H1b = 1, 2, 3, 4

Then review these MDS items:

- **B5a-f = 1, 2**

If any item at B5a-f is present, further assessment is needed. Often when delirium is treated, incontinence will resolve. In the meantime, a regular toileting

program may help.

If H1a & H1b = 1, 2, 3, 4

Then review these MDS items:

- **E1a-p = 1, 2**
- **I1ee = checked**

Severe depression can result in loss of motivation to stay dry or clean. Prompted toileting is often helpful as a means of positive reinforcement.

If H1a & H1b = 1, 2, 3, 4

Then review these MDS items:

P4a-e = 1, 2

Daily use of restraints can result in a resident's inability to get to the toilet; quick staff response is necessary. *Reference: RAI Manual, Appendix C, pages 30-39*

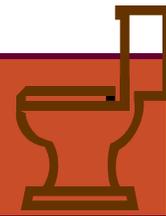


If the skin, or whatever is next to the skin, gets wet—it should be counted as an episode of incontinence

ALERT!
MDS Manual Revision—Be sure to check the web for quarterly MDS Manual Revisions
To Download Manual
www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp

A Season of Losses—Continence

Section H1—The Assessment Process (Continued from page 1)



three times per week.; **4 = Incontinent**—refers to inadequate control, i.e., bladder incontinent episodes occur multiple times daily and bowel incontinent episodes are all or almost all of the time.

You will choose one response to code the level of bladder continence and one response to code the level of bowel continence for the resident over the last 14 days.

Remember to **code for the resident's actual bowel and bladder continence pattern**, i.e., the frequency with which the resident is wet and dry during the 14-day assessment period. **Do not record** the level

of control that the resident **might have achieved** under optimal circumstances.

For bladder incontinence, the difference between a code of “3” (Frequently Incontinent) and “4” (Incontinent) is **determined by the presence (“3”) or absence (“4”) of any bladder control**.

To ensure accurate coding in H1a (Bowel Incontinence) and H1b (Bladder Incontinence), assessors must use multiple sources of information to code accurately: resident interview and observation, review of the clinical record (i.e., urinary and bowel elimination flow sheets), and discussions with direct

care staff across all shifts.

In assessing your residents, remember many people with poor control will try to hide their problems out of embarrassment or fear of retribution. Others will not report problems to staff because they **mistakenly believe** that incontinence is a natural part of aging and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many elders are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive and straightforward manner. *Reference: RAI Manual, Chapter 3, Pages 119-122*

Nursing Home Goal—Highest Practicable Level of Functioning Stay Informed—Section H1—Continence in Last 14 Days



Atrophic Vaginitis, caused by a reduced amount of the female hormone, estrogen, causes or contributes to incontinence in many women. Optimally, a pelvic exam checks for signs of atrophic vaginitis. Atrophic vaginitis can be treated with a low dose of oral conjugated estrogens. Contraindications to estrogen therapy include a history of breast or

endometrial cancer.

Other potential causes or factors contributing to incontinence or use of catheters include: medication side-effects, pain, excessive or inadequate urine output. A doctor or a nurse practitioner can identify potentially life-threatening conditions that cause or accompany urinary incontinence. These include bladder cancer

or bladder stones, prostate cancer, spinal cord or brain lesions (e.g., slipped discs and metastatic tumors), poor bladder compliance, and tabes dorsalis. Working the Urinary Continence RAP helps you address these issues. **Highest practicable level of functioning = following the MDS & RAP process.** *Reference: RAI Manual, Appendix C, pages 30-39*

SCENARIO QUIZ—Section H1—Continence



Mrs. H's Annual Assessment is due September 30, 2007. Her Assessment Reference Date (ARD) is set for September 25, 2007. On September 15, 2007, Mrs. H attended an activity where a clown performed. The skit was so funny, she laughed until she dampened

her underwear with urine and had to leave to change. She told you she was so embarrassed and emphasized, “This is the first time this has happened to me in years”. The CNAs on all shifts state they have not changed wet sheets and report no other “wet” episodes. They deny find-

ing any wet underwear or clothing in the resident's room. When you go into Mrs. H's room to talk with her, you note her room has no urine odor.

How will you code H1b – bladder continence?



MARK YOUR CALENDAR!



Upcoming MDS Training

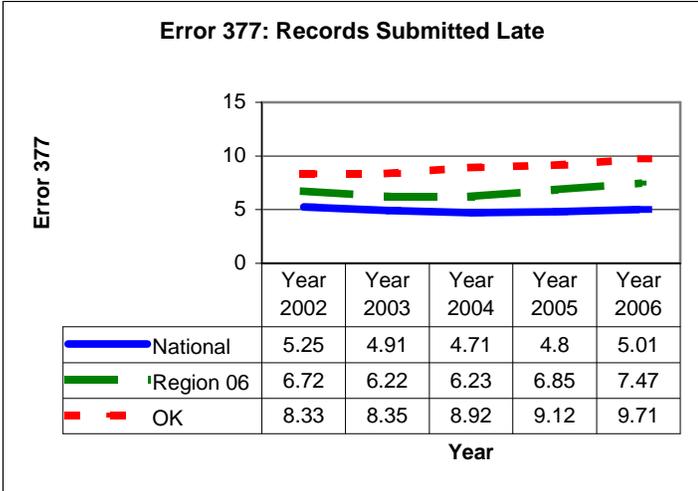
- **October 10, 2007**
MDS Activities RAP Workshop
- **November 7 2007**
Automation Workshop

See Training Calendar at: www.health.ok.gov/PROGRAM/qies/mds/index.html

MDS Automation Tips

Bob Bischoff Program Manager, MDS/OASIS Automation

Please, lets work on submitting our assessments timely. Thanks.



Broadband in—Modem out
 January 2008, facilities can transmit MDS data without using the old fashion modem. Download the instructions and dialer at: www.qtso.com/mdcn.html
 Contact the MDS Help Desk for any additional assistance.

Scenario Answer from page 3

H1b = 1 (Usually Continent—Bladder)

Rationale:

From resident observation and interview with resident & CNAs across all shifts, it seems the only episode of wetness occurred on September 15, 2007 when Mrs. H experienced stress incontinence from laughing at the skit. The RAI Manual states that “If the resident’s skin gets wet with urine, or whatever is next to the skin gets wet, it should be counted as an episode of incontinence—even if it’s just a small volume of urine, for example, stress incontinence.”

Reference RAI Manual, Chapter 3, Page 120

Oklahoma Misses the Mark on MPAF

Greater than 50% of our skilled nursing facilities are not taking advantage of the **MPAF** form. The **Medicare Prospective Payment System Assessment Form** is a four page assessment that was implemented July 1, 2002 and can be utilized for all PPS assessments.

The **MPAF** should be available in your MDS software and will save you completing 3 pages for all skilled assessments. If you are still utilizing the 7 page PPS assessment, the state will only retain the 4 pages of **MPAF** items when the assessment is transmitted.

The **MPAF** can also be used when dual coding a skilled assessment along with a quarterly. Since Oklahoma utilizes the 2-page quarterly, the **MPAF** is not used for OBRA only quarterlies. Further detail can be located on page 2-34 of the RAI manual, scenario # 3.

CASPER Reports New Look

CMS has added a new folder to CASPER. The folder is named **My Library** and is more user friendly when requesting the same reports on a routine basis. The use of this “time saver” will be covered in our November Workshop.

Time Saver Tip

Section W
 It’s time again to complete Section W2a and W2b on all MDS assessments and tracking forms.

The season begins October 1, 2007 for assessing W2a and W2b and ends June 30, 2008.

Contact software vendors to make sure you are good to go and avoid internal corrections & double transmission of records due to inaccuracies .

What’s due when?

The best one page charts for OBRA and PPS assessments are located in the RAI manual.

- OBRA: page 2-22**
- PPS: page 2-29**
- Locate, Copy, and Utilize.**