



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:**

- Appliances and Programs—Section H3a & H3b—The Assessment Process
- A Fond Farewell
- The MDS Connection
- Automation Tips, Reminders & Updates

Volume 3 Issue 3

April, 2008

**To Go or Not to Go—That is the Question  
Section H3a & H3b—The Assessment Process**

*Written by Sharon Warlick, RN, BA  
Former Director, MDS/OASIS*



Have you ever been to a workshop where the speaker prattles on and on? You sit as the speaker drones endlessly. Your one gallon consumption of coffee punches the sides of your one quart bladder screaming for release. You look around the room to see how conspicuous you will be if you get up and leave. “Not a good idea,” you say to yourself, since you are sitting in the middle of the front row and you would have to scoot in front of all those people. So you continue to sit, the bladder continues to balloon, and your attention is focused on your immediate need instead of the speaker. Soon, you glance

at the agenda. The break is only five minutes away. You convince yourself, “I can hold it.” But the five minutes comes and goes and the speaker continues to chatter.

Finally, with your bladder set on “burst”, you stand



**GOAL  
Highest Practicable Level of  
Functioning**

and start your trek. While stomping on feet, bumping people’s knees, and knocking a pile of paper to the floor, you convince yourself, “It’s worth it.”

At the end of the row you turn, race up the stairs, push open the door to the ladies room, and slam the door into seven women ahead of you in line.

Now, standing with legs crossed and a determined look on your face, all your concentration is focused on your one goal of holding ‘it’ until you can get to the toilet. Not a good position to be in but our seniors face similar situations daily while in your care.

*(Continued on page 2)*

**A Fond Farewell**



By the time you read this, I will have been retired and living on a mountain in Montana for three months. I couldn’t leave, however, without wishing you all a fond farewell and letting you know how much I enjoyed working with each of you whether it was in workshops or through the QIES Help Desk.

Throughout my 6+ years at the Oklahoma State Department of Health working as the State RAI Coordinator, I felt I learned as much from each of you as you learned from me. My passion throughout this time has been to

improve care for the elderly and help folks understand the unique times our elders face in adjusting to their new lifestyle.

The last MDS workshop I presented was on the Activities RAP. I was encouraged and delighted to hear the many innovations you, as providers, have implemented for your residents. These varied activities will have a positive impact on our seniors quality of life.

So, for now, so long—it was great working with you.

*Sharon*

**Inside this issue:**

To Go or Not to Go	2
The MDS Connection	2
To Go or Not to Go	3
Nursing Home Goal	3
Scenario Quiz	3
MDS Automation Tips	4
Training Calendar	4



## To Go or Not to Go—That is the Question Section H3a & H3b

### The Assessment Process *(continued from page 1)*

Changing wet garments is not included in the concept of a scheduled toileting plan

The difference between you and your resident, however, is you are still in control of your decisions and have the ability to carry them out, (e.g., “I decide to get up, even though it is not break time, and go to the bathroom and I, physically, can get up and go to the bathroom.”)

Many resident’s don’t have that luxury. They depend on others to help them make that race to the bathroom and in many cases, the time between pressing the call light for assistance and help actually arriving is much more than five minutes.

When time runs out, and the bladder can hold no more, we call the resident incontinent. In this issue, we will look at two essential programs in your facility dealing with inconti-

nence, i.e., **H3a**—Any scheduled toileting plan and **H3b**—Bladder retraining program.

First we’ll look at the definition for **H3a—Any Scheduled Toileting Plan**. It is a plan for bowel and/or bladder elimination whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. It includes bowel habit training and/or prompted voiding. **To code H3a**, the clinician must understand the concepts featured in this item.



There are three

key ideas captured at H3a: 1) scheduled, 2) toileting, and 3) program. The word “**scheduled**” refers to performing the activity according to a specific, routine time that has been clearly communicated to the resident (as appropriate) and caregivers.

The concept of “**toileting**” refers to voiding in a bathroom or commode, or voiding into another appropriate receptacle, (i.e., urinal, bedpan). **Changing wet garments is not included in this concept.**

A “**program**” refers to a specific approach that is organized, planned, documented, monitored, and evaluated. A scheduled toileting program could include taking the

*(Continued on Page 3)*

**Three key ideas captured at H3a:  
Scheduled  
Toileting  
Program**



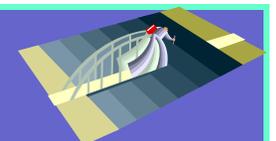
QIES  
HELP DESK  
405-271-5278

Bob Bischoff  
Automation

Michael Jordan  
Technical

Kristi Touboulie  
Training

## The MDS Connection Section H3a & H3b



**If H3a—(Any Scheduled Toileting Plan) = Checked**

**Then** review this MDS item:

- **G1iA (Self-Performance Toilet Use) = 2, 3, or 4 or**
- **G1B (Support Provided) = 1, 2, 3**

Review the residents Self-Performance and Support Needs for toileting. Understanding the resident’s needs help clinicians develop appropriate interventions, time schedules, and staffing requirements to assure the resi-

dent attains continence.

**If H3a—(Any Scheduled Toileting Plan) = Checked**

**Then** review this MDS item:

- **C6 (Ability to Understand Others) = 1, 2, or 3**

The resident’s ability to understand others has a tremendous impact on the type of interventions clinicians will use in care plan development. Understanding how a resident understands will assist clinicians in providing appropriate information to the resident about what the toileting plan is, what the schedule is, who

will be assisting with the toileting, and how the resident will let staff know when they need to toilet before the scheduled time.

This scheduled toileting plan includes all ways the resident uses to toilet, (i.e., bedpan, urinal, bedside commode, toilet room). Be sure staff understand that continence does not refer to the resident’s ability to toilet self. A resident can receive extensive assistance in toileting and yet be continent as a result of the staff’s help. *Reference: RAI Manual, Chapter 3, pages 119-125*



**Breakthrough incontinence? This is a good time to reevaluate the effectiveness of the current care plan!**

## To Go or Not to Go—That is the Question Section H3a & H3b The Assessment Process *(continued from page 2)*

resident to the toilet, providing a bedpan at scheduled times, or verbally prompting to void.

If the scheduled toileting plan is recorded in the care plan, staff are actually toileting the resident according to the specified times, documenting results, the nurse is monitoring the resident's responses, and the nurse is evaluating the resident's progress toward the goal, check Item H3a.

If the resident also experiences breakthrough incontinence, this would be a good time to reevaluate the effectiveness of the current plan by assessing if the resident has a new, re-

versible condition causing a decline in continence (e.g., UTI, mobility problem, etc.), and treating the underlying cause.

**H3b—Bladder Retraining Program** is defined as a retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability. This program adheres to the same requirements as described in H3a. The program must be a specific ap-

proach that is organized, planned, documented, monitored, and evaluated. Evidence of the program will be in the documented care, the monitoring of the resident's response, the evaluation by the nurse as to the effectiveness of the interventions, and care plan revisions when needed.

A resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff. And, of course, the resident should be aware of the schedule as well.

*Reference: RAI Manual Chapter 3, pages 124-125*



**ALERT!  
MDS Manual  
Revision—  
January 2008  
Be sure to  
check the web  
for quarterly  
MDS Manual  
Revisions  
To Download  
Manual  
[www.cms.hhs.gov/nursinghomequalityinits/20\\_nhqimds20.asp](http://www.cms.hhs.gov/nursinghomequalityinits/20_nhqimds20.asp)**

## Nursing Home Goal— Highest Practicable Level of Functioning Stay Informed—Section H3a & b—Toileting Programs

For residents on a scheduled toileting plan, the care plan should at least note that the resident is on a routine toileting schedule. Good clinical practice dictates that a resident's specific toileting schedule must be in a place where it is clearly communicated, available to and easily accessible to all staff, including direct care staff.

If the care plan is the resource used by staff to be made aware of resident's specific toileting schedule, then the toileting schedule should appear there.

Facility staff may list a resident's toileting schedule by specific hours of the day or by timing of specific routines, as long as those routines occur around the same time each

day. If the timing of such routines is not fairly standardized, specific times should then be noted.

Documentation in the clinical record should evaluate the resident's response to the toileting program, progress toward goals, and revision to the care plan when needed. *Reference: RAI Manual, Appendix C, page 125*

## SCENARIO QUIZ—Section H3a and H3b



Clinical staff talked about putting Mrs. H on a scheduled toileting plan. They identified that she was frequently incontinent and noted in the care plan to "toilet q 2 hours."

In reviewing the clinical record, the nurse noted that sev-

eral days during one week an aide got Mrs. H to the toilet in time. Most other days, due to staffing, the aides did not follow the care plan and were not able to get Mrs. H to the toilet in time. Additionally, when questioning the aides, the nurse

found all direct care staff were not told of any specific schedule and, therefore, did not follow it. Further, there was no documentation in the clinical record regarding the resident's response. **How will you code Section H3a?**

# MDS Automation Tips

Bob Bischoff—MDS/OASIS Automation Coordinator

## MARK YOUR CALENDAR!



### Upcoming MDS Training Tentative

- **April 24, 2008—Canceled**  
Clinical Focus
- **August 14, 2008**  
Clinical Focus

### For more, see the MDS Training Calendar at:

[http://www.ok.gov/health/Protective\\_Health/Quality\\_Improvement\\_and\\_Evaluation\\_Service/Minimum\\_Data\\_Set/Educational\\_Resources/index.html](http://www.ok.gov/health/Protective_Health/Quality_Improvement_and_Evaluation_Service/Minimum_Data_Set/Educational_Resources/index.html)

### Broadband Now Available

CMS has developed a method for transmitting your assessments through broadband. The software with instructions can be downloaded at:

<https://www.qtso.com/mdcn.html>

Contact the QIES Help Desk for assistance.

### Answer: Scenario—Section H3a

H3a Any scheduled toileting plan = unchecked

#### Rationale:

Even though the care plan stated “toilet q 2 hours”, the staff were not actually toileting the resident according to the multiple specified frequencies. There is no evidence the resident’s response was monitored, no documentation, and no evaluation. Simply stating in the care plan “toilet q 2 hours” does not meet the criteria required for a scheduled toileting plan. The plan must actually be carried out along with monitoring and evaluation. Obviously, this was not done in this instance.

## Where Oklahoma stands with the Nation and Region 6



### 5.1 Low-risk residents who lost control of their bowels or bladder

	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007	Q3, 2007
National	47.6	47.9	48.2	48.3	48.5
Region 6	41.4	41.8	42.2	42.4	42.5
OK	37.1	37.5	37.8	38.2	38.0

### 5.2 Residents who have/had a catheter inserted and left in their bladder

	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007	Q3, 2007
National	7.7	7.6	7.7	7.7	7.6
Region 6	7.9	7.8	8.0	7.9	7.6
OK	8.1	8.7	8.9	8.2	8.3

### 5.3 Prevalence of occasional or frequent bladder or bowel incontinence without a toiletting plan

	Q3, 2006	Q4, 2006	Q1, 2007	Q2, 2007	Q3, 2007
National	45.3	45.2	45.6	45.5	45.6
Region 6	68.6	68.7	69.5	69.5	69.6
OK	63.5	62.8	64.7	66.2	67.4

Well, we sure could improve on item 5.3 listed above. On average, Oklahoma is 20 points above the Nation and rising. Let’s challenge ourselves to improve!

## Sharon, we miss you!

I’ve known many folk in my day, but I have to say, none like Sharon. She was very passionate about the MDS. She taught us all how to utilize MDS to get our residents to their “highest practicable level of functioning”, how to associate one item with another, how to correct, how to interpret, and many, many more valuable insights to better care for our residents. I loved the very special stories she incorporated into her many 3-day training sessions. She was able to make us think, problem solve, and improve MDS accuracy. She was even known to get her employees to dress up in funny clothes for those great “skits” she put together. We all miss you. Take Care.

*Bob*

Sharon’s departure from QIES was bittersweet. We were excited to see her realize a dream she had talked about for many years, but at the same time wished she didn’t have to leave us. Even though Sharon and her husband vacationed in Montana every year, that just wasn’t enough. They were struck by the beauty of the area, and enjoyed hiking, canoeing, kayaking and all the folk lore that goes along with the history of Montana. Sharon often told us that the mountains were “calling her.” And this time she answered for good. We miss her knowledge and experience and her ability to explain the pieces of the MDS “puzzle” so all could understand. We miss her advocacy for the residents, and her courage to say what she believed even though it might not be popular. We bid Sharon a fond farewell, with best wishes for a wonderful life.

*QIES Staff*

**Are you going to be ready?** All the rumble at CMS, is that we will be transitioning to MDS 3.0 effective October 1, 2009. Detailed information is available at:

[www.cms.hhs.gov/NursingHomeQualityInits/25\\_NHQIMDS30.asp#TopOfPage](http://www.cms.hhs.gov/NursingHomeQualityInits/25_NHQIMDS30.asp#TopOfPage)