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 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)
To Go or Not to Go—That is the Question
Section H3a & H3b
The Assessment Process (continued from page 1)

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

First we will 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: Scheduled Toileting Program

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)

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 resident 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
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, reversible 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 approach 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.

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 Chapter 3, pages 124-125

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.

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 several 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?
Where Oklahoma stands with the Nation and Region 6

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>47.6</td>
<td>47.9</td>
<td>48.2</td>
<td>48.3</td>
<td>48.5</td>
</tr>
<tr>
<td>Region 6</td>
<td>41.4</td>
<td>41.8</td>
<td>42.2</td>
<td>42.4</td>
<td>42.5</td>
</tr>
<tr>
<td>OK</td>
<td>37.1</td>
<td>37.5</td>
<td>37.8</td>
<td>38.2</td>
<td>38.0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>7.7</td>
<td>7.6</td>
<td>7.7</td>
<td>7.7</td>
<td>7.6</td>
</tr>
<tr>
<td>Region 6</td>
<td>7.9</td>
<td>7.8</td>
<td>8.0</td>
<td>7.9</td>
<td>7.6</td>
</tr>
<tr>
<td>OK</td>
<td>8.1</td>
<td>8.7</td>
<td>8.9</td>
<td>8.2</td>
<td>8.3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>45.3</td>
<td>45.2</td>
<td>45.6</td>
<td>45.5</td>
<td>45.6</td>
</tr>
<tr>
<td>Region 6</td>
<td>68.6</td>
<td>68.7</td>
<td>69.5</td>
<td>69.5</td>
<td>69.6</td>
</tr>
<tr>
<td>OK</td>
<td>63.5</td>
<td>62.8</td>
<td>64.7</td>
<td>66.2</td>
<td>67.4</td>
</tr>
</tbody>
</table>

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 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.

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

Bob Bischoff—MDS/OASIS Automation Coordinator

Sharon, we miss you!