# Quality Measure Tip Sheet

Incontinence (Long Stay)

## MDS Coding Requirements

- Look back period is 7 days.
- Frequently Incontinent of urine: resident was incontinent seven or more times but had at least one continent void.
- Frequently incontinent of bowel: resident was incontinent of bowel more than once but had at least one continent bowel movement.
- Always incontinent of urine and bowel: resident had no continent voids of urine or bowel movements.
- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.

## Ask These Questions

MDS

- Was the MDS coded per Resident Assessment (RAI) Requirements?
- Was the resident correctly coded for cognitive impairment in C0500, C0700, C1000? Severe cognitiveimpairment will exclude a resident from this measure.
- Was the resident correctly coded in G0110A1, G0110B1, G0110E1? A resident that is coded as totallydependent in any of these areas is excluded from this measure.
- Was the resident properly coded as being comatose? A resident that is comatose is excluded from this measure.

## New Incontinence

- Is the staff member's coding documentation accurate?
- Are underlying conditions reviewed and treated for potential causative factors for incontinence (e.g.diabetes, kidney dysfunction, HTN, medication side effects, etc.)?
- What is your system for staff communication regarding changes in resident condition?

## Incontinence Programs

- Was the resident evaluated for elimination patterns for at least three days and were toilet programsdeveloped to address individualized patterns (i.e., prompted voiding and habit training are not effectiveprograms with residents with mid to late stage dementia).

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## **Incontinence Programs** (continued)

- Is the resident re-evaluated for elimination patterns whenever there is a change in condition, physical ability,or urinary tract function?
- Do you have therapy and/or restorative involvement in your incontinence programs?
- Is continence managed through a check and change program if the resident is not appropriate for a toilet program?

## Documentation

- Is there documentation to support the:
  - Implementation of an individualized resident-specific toilet program based on an assessment of theresident's unique voiding pattern?
  - Communication of the individualized program to staff members and resident through the Plan of Care?
  - Resident's response to the program and subsequent evaluations?

This Tip Sheet contains information from the MDS 3.0 RAI Manual accessed in October 2019 and MDS 3.0 Quality Measure User's Manual accessed in January 2020. The information presented is intended to enhance understanding of Quality Measures. The content does not take the place of, and is not at all inclusive of the comprehensive information and instructions provided by the MDS 3.0 RAI Manual and the MDS 3.0 Quality Measure User's Manual. Any updates to both the RAI and QM manual will supersede this content. Reader should utilize the most current manuals at all times.