

INCONTINENCE MANAGEMENT:

Training Module

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About This Module

ABOUT THIS TRAINING MODULE

In this training module, we present instructions and protocols for accomplishing each of the four steps required to implement an effective prompted voiding program. The module starts with a list of learning objectives, followed by an overview of prompted voiding.

Next, we present the four implementation steps:

1. Conduct a basic resident evaluation
2. Assess resident responsiveness to prompted voiding
3. Implement time-saving strategies to maintain prompted voiding programs
4. Conduct periodic control checks to help ensure incontinence care quality

How long will it take to read these "how to" sections? About 20-30 minutes. Not enough time now for the task? Then print the module in full, or just the pages you select, so that you can browse through them at your leisure.

Elsewhere in this module - Links, FAQs, Related Studies - we provide guidance and referrals to other resources that can help you improve incontinence care in your facility. And via our discussion board you can chat with other long-term-care providers about the topic.

CONTACT US

We've tried to be comprehensive, but if there is something you can't find, or if you have unanswered questions, comments, or concerns, please feel free to contact us at the Center for Quality Aging:

Vanderbilt University Medical Center
Center for Quality Aging
1611 21st Ave South Rm S1121
Medical Center North
Nashville, TN 37232-2400
www.vanderbiltcqa.org

Learning Objectives

At the end of this training module, you will be able to:

that govern nursing home care and best practice guidelines for incontinence care.

- Demonstrate knowledge of the importance of conducting a comprehensive evaluation of residents who are incontinent of urine.
- Demonstrate knowledge of the benefits of prompted voiding for incontinent nursing home residents.
- Compare and contrast prompted voiding to other treatment and management options for incontinent nursing home residents.
- Describe and implement the prompted voiding procedure with incontinent residents. Assess a resident's responsiveness to prompted voiding.
- Demonstrate knowledge of the management options for incontinent residents who are not responsive to prompted voiding.
- List at least three modifications that can make a prompted voiding program potentially more feasible to implement.
- Create a control chart for use in monitoring a prompted voiding program.
- Describe and implement the procedure for conducting control checks as a means of evaluating a prompted voiding program.

All procedures presented in this module are in accordance with the federal regulations

Introduction

Learn how the four-step prompted voiding program can individualize incontinence care for nursing home residents, improving outcomes and quality of life without overwhelming staff resources.

BETTER INCONTINENCE CARE NEEDED IN NURSING HOMES

Incontinent nursing home residents are among the frailest of the frail. Most have physical impairments that restrict their mobility and many suffer from dementia. Given the profound functional and cognitive losses they've experienced, you might think these residents would be poor candidates for prompted voiding programs that improve continence. Not so. A significant proportion of these severely impaired residents are motivated to stay dry. And that fact, perhaps more so than any other, dramatically demonstrates how important this personal care area is to nursing home residents. It restores a shred of dignity to lives that increasingly are insulted by loss.

Nursing home staff, on the other hand, view incontinence care as one of the most "onerous and difficult" aspects of their job (1). It is also, they say, inordinately time consuming if done properly, which goes a long way—but not all the way—toward explaining why most nursing homes struggle with this care area.

Consider the facts:

- More than 50% of nursing home residents suffer from urinary incontinence, and most of them have both physical and cognitive problems that prevent them from independently using the toilet (2).

- The vast majority of these residents, 80%-90%, use diapers and some form of staff toileting assistance to manage incontinence (3).
- Incontinent residents need toileting assistance three to four times within a 12-hour period to stay dry (4-6).
- Studies show, however, that they are rarely toileted and are not changed after every wet episode (5,7). Staffs normally change residents an average of 1.34 times per 12 hours and provide toileting assistance an average of .5 times, and very rarely more than twice a day.

Lack of staff time partly explains the latter findings, but lack of staff knowledge is another, often un-credited culprit. Unfortunately, this overlooked second problem can exacerbate the first.

PROMPTED VOIDING PROGRAMS IMPROVE CONTINENCE

What knowledge does nursing home staff lack? Many seem unaware of key findings from more than 10 years of research on prompted voiding programs, the most extensively evaluated toileting assistance intervention for nursing home residents. Prompted voiding programs are designed to create awareness among residents of their continence status (i.e., whether they are wet or dry) and to encourage them to ask for toileting assistance. When implemented properly, the programs work. Here's what the findings show:

- Prompted voiding results in a 40% to 50% overall reduction in the frequency of daytime urinary incontinence (4, 8).
- Between 25% and 40% of incontinent residents will respond to prompted voiding, with a reduction in their

incontinence frequency from three to four episodes per day to one per day (8-9).

- Residents who are most responsive to prompted voiding can be easily identified in a three-day trial of the intervention (10).
- Even residents with severe cognitive and physical impairments have proven responsive to prompted voiding (10).

EFFECTIVE PROGRAMS LACKING IN NURSING HOMES

One obvious key to program success is assessment of resident responsiveness to the intervention. In the absence of these initial assessments, it is impossible to objectively determine who should receive toileting assistance and who should be managed on a check-and-change program. Nevertheless, in a recent study of 14 nursing homes, we found that all the facilities failed to evaluate incontinent residents' responsiveness to toileting assistance, a finding in keeping with those from other studies (1, 11).

Without the benefit of a resident assessment, nursing home staff members often attempt to toilet all incontinent residents, but then fall short of recommended care standards due to excessive workloads (11). Observed one nurse aide, "All these people are not going to get the continence care they need because we don't have enough time or the people we need to get them up every two hours. It's not fair to the residents (12)." In some facilities, a failure to target toileting assistance discriminates in favor of the most able-bodied, clear-minded residents, reserving the poorest care for the frailest (11).

On the flip side, with better targeting of toileting assistance, not only is improved

care more feasible to provide, but it could be easier to sustain, for it allows nursing home staff to "recognize the fruits of their labors, and...use principles of continuous quality improvement to maintain prompted voiding (13)."

THE (MANY) BENEFITS OF PROMPTED VOIDING PROGRAMS

Corrective action is needed. Besides being "the right thing to do," providing proper toileting assistance to residents makes sense clinically and economically. Urinary incontinence is estimated to cost nursing homes close to \$5 billion annually, including costs for laundry, staff time, and supplies (14). Some of these costs are due to staff failure to identify residents responsive to toileting assistance. This oversight often means that staff will waste time trying to toilet some residents who are unresponsive to their help while better candidates go without proper assistance. Urinary incontinence also is associated with a high rate of infection, requiring costly medical treatment both in the hospital and within the nursing home. Prevention programs such as prompted voiding address both problems, enhancing clinical outcomes for residents while possibly improving the facility's bottom line.

Prompted voiding programs also offer public relations value. In one consumer survey, we asked family members and older board-and-care residents to compare the value of an intervention that improves continence to other nursing home perks such as improved meals or moving from a three- or two-person room to a single. By wide margins, the respondents rated the incontinence prevention program higher than the other, more customary options (5).

Additionally, prompted voiding programs can contribute to better scores on publicly reported quality measures for nursing homes. The Centers for Medicare and Medicaid Services now publishes nursing home “report cards” on its consumer website, www.medicare.gov. Among the quality measures reported are the percentage of residents in a facility: 1) with a catheter; 2) with a urinary tract infection; and 3) who lose control of their bowels or bladder. By improving continence among residents, prompted voiding programs may produce better “grades” on a facility’s report card.

Finally, improved incontinence care can improve staff morale. Deborah Lekan-Rutledge at the Duke University School of Nursing writes about the aftereffects of implementing a comprehensive urinary incontinence (UI) management program in one nursing home: “The DON reported that family complaints on Monday mornings went from 20 to virtually none after implementing prompted voiding. Families were ecstatic about the UI program...Additionally, the nurse aides recognized the restorative nature of their role and re-titled themselves ‘Quality Care CNAs,’ reflecting pride and ownership of the program (15).”

Some staff even find prompted voiding, well, inspiring. Consider this little ditty written by DON Fran Bollman at Manor Care in Elgin, Illinois:

THE TOILETING SONG **Sung to the tune of “I Will Survive”**

**At first you were afraid
You were petrified
Kept thinking you could never get it
done in just one day.
But then you got into the swing
And toileting became your thing
And you grew strong
And your residents went along.**

**So just go back.
Take them again.
You’ve got to get them in the habit
If you’re going to win.
You’ve got to get them used to it.
You’ve got to get them in the groove.
It’s just your prompting Q 2 hours that
will get them all to move.**

**So close the door.
Tell them to go.
Just keep them dry
And help prevent their butts from
getting sore.**

**You are the only ones to try
To keep your residents dry.
Did you crumble?
Did you hang it up and lie?**

**Oh no-no lie.
You will survive
And your residents will be the ones to
reap the prize
You’ve got to keep on prompting them.
You’ve got to get them all in line.
And you’ll survive.
And your residents will thrive.**

You will survive!

BUT BEFORE YOU START...

Two prerequisites are recommended before you start implementation of a prompted voiding program:

- Enlist top-level support from administrators and management staff to facilitate acceptance of the new program by direct care staff.
- Allow extra time at the beginning not only to climb the learning curve and but also to assess all eligible residents and get them on board the program; however, the longer you implement the intervention, the less time it will consume.

YOUR ASSIGNMENT

Find out how often incontinent residents in your facility receive incontinence care. Ask between five and ten incontinent residents how often they were checked and changed that day or received help to the toilet from staff. Be sure to interview some residents with moderate to severe cognitive impairments. (We have found that cognitively impaired residents usually give reliable reports of their daily care.)

Were the residents you interviewed on schedule to receive toileting assistance three to four times during the day, the amount needed for them to stay dry? Please contact us to share your findings. We'll report your feedback in updates to this site.

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Many of the articles cited below, plus a few others, are summarized on our *Related Studies* page.

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Step 1: Conduct a Basic Resident Evaluation

Learn about the benefits of and procedures for conducting this critical first step in managing urinary incontinence in nursing home residents

COMPREHENSIVE ASSESSMENT IDENTIFIES CAUSE OF AND TREATMENT FOR URINARY INCONTINENCE

There are many potential causes of urinary incontinence. Consequently, there are many potential treatments. Determining the first so that you can decide upon the second is the primary goal of a basic resident evaluation, a first step recommended in all best-practice guidelines for managing urinary incontinence.

Though this first step is clearly a cornerstone for effectively managing incontinence, even nursing homes that purportedly provide quality services in this area often fail to follow through with recommended assessment procedures (1). In one study conducted in 30 nursing homes, we found that the staff (and here we include physicians) had obtained targeted histories for most incontinent residents, but had performed comprehensive physical exams for less than 14% of these residents (1). Rarer still were recommended dip stick urinalyses, post-void residual measurements, and 24-hour voiding records.

BENEFITS OF COMPREHENSIVE ASSESSMENT

There may be several reasons for skipping critical assessment tasks, including lack of time, staff inexperience, and unfamiliarity

with recommended guidelines, but if you give this first step the attention it deserves, your facility, residents, and staff will reap the benefits:

- Residents with reversible causes of urinary incontinence will get proper treatment, which in turn will help them maintain their independence.
- Staff will be able to better target time-consuming toileting assistance to residents who truly need it.
- And your facility may score better on publicly reported quality measures that reflect the quality of incontinence care.

INDICATORS OF A QUALITY ASSESSMENT

What exactly does a basic resident assessment of urinary incontinence entail? We at the Vanderbilt Center for Quality Aging worked with UCLA colleagues and researchers at RAND, a southern California think tank, to develop a series of quality indicators (QI) related to incontinence care for nursing home residents. Of the nine QIs we generated, three pertain to the assessment process. Presented as a series of if/then statements (so there's no mistaking your obligations), these QIs outline the assessment process:

Urinary Incontinence Assessment Quality Indicators

1. IF a nursing home resident has urinary incontinence on admission or the new onset of urinary incontinence that persists for over one month,

THEN a targeted history should be obtained that documents each of the following:

- Mental status
- Characteristics of voiding
- Ability to get to the toilet
- Prior treatment for urinary incontinence
- Importance of the problem to the residents

2. IF a nursing home resident has new urinary incontinence that persists for over one month or urinary incontinence on initial assessment,

THEN a targeted physical should be performed that documents:

- Rectal exam
- Skin exam

- Genital system exam (including a pelvic exam for women)

3. IF a nursing home resident has new urinary incontinence that persists for over one month or urinary incontinence on initial assessment,

THEN the following tests should be obtained or there should be documentation explaining why the test was not completed:

- Dipstick urinalysis
- Post-void residual
- 24-hour voiding record

It should be noted that these QIs are not, technically speaking, practice guidelines, though they are based closely on existing guidelines. Practice guidelines, such as those available from the American Medical Directors Association, "aim to define optimal or ideal care in the context of complex decision-making," writes RAND. In most nursing homes, however, optimal care is virtually synonymous with impossible care; it simply cannot—and almost certainly will not—be implemented under usual conditions. So with a nod to real life, the QIs lower the bar. Explains RAND: They "set a minimal standard for acceptable care—standards that, if not met, almost ensure that the care is of poor quality (emphasis is ours)."

Based on expert opinion and existing best-practice guidelines, all of our QI-associated assessment tasks are *both* related to positive outcomes for residents *and* feasible for nursing home staff to implement.

TREATMENTS FOR URINARY INCONTINENCE

Depending on the outcomes of the basic evaluation, four broad types of treatment and several combinations of treatments may be justified. These include:

Treatments for Urinary Incontinence

Drug Therapy

Surgery

- Bladder neck suspension and repair of the pelvic prolapse for women with stress incontinence
- Insertion of artificial urinary sphincters
- Removal of anatomical obstructions

Behavioral Interventions

- Bladder retraining
- Pelvic muscle rehabilitation (Kegel exercises)
- Biofeedback
- Vaginal weights to strengthen pelvic muscles
- Toileting assistance protocols, including prompted voiding

Other interventions

- Electrical stimulation
- Intermittent catheterization
- Chronic indwelling catheters
- Intravaginal supportive devices (e.g., pessary)

Although there are few comprehensive studies on the prevalence of incontinence treatment strategies for nursing home residents, existing data suggests that indwelling urethral catheters are used by 4% to 12% of residents (2) and medications by

3% to 10% (3—unpublished data from the pharmaceutical industry), with the remaining majority using diapers with some form of toileting assistance. As a general rule, incontinent nursing home residents are considered poor candidates for the other behavioral interventions largely because most of them have cognitive impairments that prevent them from following complex instructions (3).

MANAGEMENT OPTIONS FOR CHRONICALLY INCONTINENT RESIDENTS

Now is the time to mention the next incontinence QI in our series of nine:

- **IF a nursing home resident remains incontinent after transient causes are treated,**
- **THEN the resident should be placed on a 3-day toileting assistance trial to assess responsiveness to prompted voiding.**

While some residents may improve continence through other treatments, the vast majority, because of their cognitive and physical impairments, will need some type of staff assistance to stay dry. Of the staff management options currently available—prompted voiding, scheduled toileting, habit training, and use of incontinence briefs—only prompted voiding has been shown in a controlled trial—the gold standard for research studies—to significantly improve continence. And the only way to reliably identify the 40% to 60% of incontinent residents who respond well to prompted voiding is to offer all otherwise untreated incontinent residents a trial run of the intervention (4). The *next step* presents procedures for this run-in trial.

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Step 2: Conduct a Brief Trial of Prompted Voiding

A three-day trial of prompted voiding is the best predictor of responsiveness to the intervention. Follow our procedures to conduct this trial and target services more effectively

WHO RESPONDS TO PROMPTED VOIDING? MYTHS AND REALITIES

Prompted voiding has been touted in nursing homes for more than a decade, yet misconceptions still abound about which residents respond best to this highly effective intervention. It's time for a reality check.

- **Myth:** Only the most cognitively intact incontinent residents respond well to prompted voiding.

Reality: Many incontinent residents with severe cognitive impairments have proven responsive to prompted voiding, with significant reductions in their wet episodes. Indeed, in a study designed to identify predictors of successful prompted voiding, we found no significant differences on Mini-Mental State scores between responders and non-responders (1). In short, cognitive status is *not* a reliable predictor of responsiveness to prompted voiding.

- **Myth:** Able-bodied incontinent residents are the best candidates for prompted voiding.

Reality: Ability to ambulate and other measures of a resident's functional status are not good predictors of responsiveness to prompted voiding (1). The reason why the most physically fit

residents are usually the most likely to receive prompted voiding is that it less time-consuming for the staff to assist these residents to the toilet. More impaired residents often respond just as well but are not given the chance.

- **Myth:** There is no reliable and *feasible* protocol that accurately predicts a resident's responsiveness to prompted voiding.

Reality: There is such a protocol (1), and it works like this: Provide prompted voiding to incontinent residents for a few days, and then analyze the results. Those who use the toilet appropriately at least two-thirds of the time are "responsive" to the intervention; those who don't are "unresponsive." The rationale behind this "run-in" approach is simple common sense: Residents either respond to prompted voiding, or they don't, and there is no reason to expect different results unless there is a significant change—for better or worse—in the resident's condition.

BRIEF TRIAL OF PROMPTED VOIDING IS BEST PREDICTOR OF SUCCESS

Results from our study on predictors of successful prompted voiding prove the point. Findings showed that a resident's appropriate toileting rate during the first three days of the intervention was a better predictor of longer term responsiveness than either the resident's cognitive status or functional ability (1). Functional status measures failed to identify a substantial proportion of residents who were responsive, and in a finding that bears repeating, cognitive status was not at all related to responsiveness. By comparison,

an appropriate toileting rate higher than 66% accurately identified the most responders while screening out the most non-responders.

We recognize that translating this finding into daily practice is challenging, but if you have ever imagined yourself in the slippers of one of these frail residents, you'll see something to celebrate here. Our findings suggest that the human spirit is so resilient that it can manage to triumph—in unpredictable fashion—over the most severe bodily onslaughts. So in one of the last places many of us would have thought to look for it, we find dramatic evidence of what could be called hope for a better life.

PROCEDURES FOR THE PROMPTED VOIDING TRIAL

Nursing home staff can honor this hope by conducting a trial run with incontinent residents. A three-day trial of prompted voiding not only identifies residents responsive to the intervention, but also generates data that answers these questions:

- Is a resident motivated to be continent, but not responsive to the prompted voiding protocol because of problems with the lower urinary tract? And if so, can these problems be treated?
- Does a resident have mobility or cognitive problems that preclude safe *independent* toileting and can these problems be treated?
- What form of urinary incontinence measurement is best for the resident who does not appear to be either a candidate for further treatment or who appears to not want further treatment?

Before starting the trial, a licensed nurse should interview participating residents to assess their motivation to toilet and to identify their preferences for toileting assistance. Use our Toileting Motivation and Preference Assessment form to guide this six-question interview and record responses. The same six questions with the addition of a seventh (also included on the assessment form) should be asked again upon completion of the three-day trial. Our research shows that residents who score two or more on the Minimum Data Set (MDS) recall scale are capable of providing reliable and meaningful responses to these interview questions. Residents who fail this cognitive screen should be excluded from interviews but should still undergo the prompted voiding trial.

The Minimum Data Set Recall Scale

Location: Section B on the MDS, Cognitive Patterns, item 3.

Procedure: Nursing home staff who know the resident should rate the resident's ability to reliably recall the following (in the last seven days): (a) current season (b) location of own room (c) staff names and/or faces (d) that he/she is in a nursing home. Residents receive one point for each item to yield a total score between 0 (unable to recall any of the four items in last seven days) and 4 (able to recall all four items). R

Residents who score two or more should be interviewed about their preferences for incontinence care.

Prompted voiding affects behavior by heightening residents' awareness of their continence status and encouraging them to ask for toileting assistance.

Five steps describe the protocol, which nurse aides should implement for three days, recording results on our Prompted Voiding Trial form:

Prompted Voiding Protocol

- 1. Contact each resident every two hours from 8 a.m. to 4 pm (i.e., four times per day).**
- 2. Focus the resident's attention on voiding by asking whether he or she is wet or dry.**
- 3. Check resident for wetness and give feedback on whether the resident's self-report was correct or incorrect (e.g., "Yes, Mrs. Jones, you are dry.")**
- 4. Whether wet or dry, ask the resident if he or she would like to use the toilet (or urinal).**
 - a. If yes:**
 - 1. Assist him/her with toileting.**
 - 2. Record the results on the bladder record.**
 - 3. Give the resident positive reinforcement by spending an extra minute or two conversing with him or her.**
 - b. If no:**
 - 1. In the event they have not attempted to void in the last four hours, repeat the request to use the toilet once or twice before leaving, and follow step 4(a) if an affirmative response is received.**
 - 2. Inform the resident that you will be back in two hours and request that the resident try to delay voiding until then.**
- 5. Record results of each wet check and toileting attempt on our Prompted Voiding Trial form.**

After the trial is completed, remember to re-interview residents using our Toileting Motivation and Preference Assessment form.

DOUBLE DUTY ASSESSMENT

The prompted voiding trial is an opportune time to complete any urinary incontinence assessment tests that are still outstanding. If you haven't already done so, take this time to:

- Collect urine for analysis
- Measure a resident's post-void residual
- Conduct a pad test for stress incontinence

TIME-SAVING TIP

Shorten the prompted voiding trial to two days. Three days is ideal; two days is an acceptable minimum; however...a third day of prompted voiding should be offered to all residents who fall short of appropriately toileting 66% of the time but who show behavioral and verbal evidence that they are motivated to stay dry.

CALCULATE APPROPRIATE TOILETING RATE TO DETERMINE RESPONSIVENESS

A resident's appropriate toileting rate during the trial period determines whether he or she is "responsive" to prompted voiding. To calculate this rate:

- Divide the total number of successful toilets by the total number of toilets plus the number of incontinent voids. Multiply the quotient by 100 to convert it to a percentage.

For example, a resident who appropriately toileted during six of the prompts on three

days and was wet on six of the prompts has an appropriate toileting rate of 50%.

Two separate major trials have determined that residents with appropriate toileting percentages above 66% will very likely continue to be continent if offered prompted voiding over longer periods (3, 4). *These residents—between 25% and 40% of all incontinent residents— should continue to receive prompted voiding.* In the next section, *Step 3*, we discuss staffing and time-saving strategies for maintaining prompted voiding programs.

TREATMENT OPTIONS FOR NON-RESPONDERS

Residents with appropriate toileting rates at or below 66% seldom show responsiveness with longer term applications of prompted voiding. Treatment options for these “non-responders” should be based on their pre- and post-trial answers to the Toileting Motivation and Preference Assessment questions and their behavior during the trial.

Non-responsive residents who express a willingness to improve continence should be further evaluated to identify all problems that are potentially treatable by other interventions. *As a general rule, any resident who attempts to toilet two times a day, even if unsuccessfully, should be considered motivated to stay dry and should thus receive a follow-up evaluation and after that, another prompted voiding trial.*

About 10%-20% of non-responders will show no willingness to improve continence. In interviews, they express no desire to be either changed or toileted more frequently. In prompted voiding trials, they show or

verbalize that toileting assistance is unwanted. These residents should be placed on a check-and-change program. No research findings to date suggest that other treatments will be more successful.

ATTENTION: MDS UPDATE

Nursing homes that act now to incorporate a toileting assessment into their incontinence management routines will be ahead of the game: The new Minimum Data Set (MDS) assessment instrument, version 3.0, slated for national implementation in October 2009, is expected to include two related items: whether the resident was offered a trial of a toileting program and, if so, how the resident responded (5).

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Step 3: Implement Time-Saving Strategies to Maintain Prompted Voiding Programs

Consider these time-saving strategies to help your facility maintain its prompted voiding program and maximize benefits for incontinent residents.

WORK SMARTER NOT HARDER TO OFFER PROMPTED VOIDING PROGRAMS

Having completed basic evaluations of incontinent residents (*Step 1*) and determined who among them is most responsive to prompted voiding (*Step 2*), you are now in a position to make informed decisions about how to efficiently use what may be your facility's most valuable resource: staff time.

Lack of staff time is one of, if not THE biggest barrier to implementing prompted voiding programs. The problem is not that prompted voiding consumes more time per episode than regular toileting assistance. We timed both interventions; on average, the first took just 12 seconds longer per episode to implement than the second (1). But toileting assistance in any form is more time-consuming to provide than checking and changing (5.5 minutes per episode), the usual care given to incontinent residents. In addition, prompted voiding must be offered every two hours, preferably between 7 am and 7 pm every day, if residents are to stay dry. By comparison, most nursing home staff provide toileting assistance less than twice a day to residents (1, 2).

We estimate that nursing homes need a staffing ratio of five residents to one nurse aide to effectively provide prompted voiding to all responsive residents (1). But the ratio

in most facilities is 10 or more residents to one nurse aide. With such severely restricted staff resources, nursing homes must work smarter in order to wring the most out of what they have. The recommendations that follow can help.

Keep in mind that not every recommendation will work well in every facility. You should decide which to implement based on your residents' needs and your facility's staff resources. And please note: We've started our list with the least restrictive recommendations. You should consider implementing these first.

CONSISTENTLY ASSIGN NURSE AIDES TO THE SAME RESIDENTS

Nurse aides who consistently work with the same residents each day grow familiar with the residents' daily routines and preferences. Such knowledge can make it easier to offer timely toileting assistance that helps keep residents drier.

INTEGRATE PROMPTED VOIDING WITH INTERVENTIONS THAT ENHANCE RESIDENTS' MOBILITY.

An integrated intervention—one that combines prompted voiding with a low-intensity exercise program—offers two major advantages:

- By improving or preventing decline in residents' ability to walk or wheel themselves, it helps enhance their ability to use the toilet independently or with minimal staff assistance. This, in turn, can reduce the amount of staff time needed to provide toileting assistance

while it also improves residents' continence.

- Combining programs uses staff time more efficiently. For starters, it cuts in half the travel time needed to locate residents (an estimated 3.4 minutes for a single trip), because only one (integrated) intervention is being provided, not two separate programs. For the same reason, it also reduces orientation time—the time it takes to introduce the service to a resident whenever it is provided.

To help you implement such a program, our training module on mobility decline prevention presents procedures for the FIT intervention, which combines prompted voiding with an exercise program. In addition to improving continence, FIT (for functional incidental training) has led to increases in residents' physical activity and their ability to stand, walk, and wheel themselves. Briefly, FIT requires nursing home staff to provide prompted voiding to incontinent residents. Before or after this incontinence care, staff encourage residents to walk or, if non-ambulatory, to wheel their chairs and to repeat sit-to-stands up to eight times using the minimum level of staff assistance possible. During one episode per day, each resident, usually while in bed, is given upper body resistance training (arm curls or arm raises). Before and after each care episode, residents are offered beverages to increase their fluid intake.

FOREGO EVENING AND NIGHTTIME PROMPTED VOIDING.

In the only study of its kind to date, we showed that prompted voiding does *not*

improve continence at night (3). So don't bother to offer it. Instead, nighttime care should be individualized, with the goals of minimizing sleep disruption and protecting at-risk incontinent residents from skin problems. Prompted voiding and other toileting assistance interventions should be reserved for those residents who are bothered by nighttime incontinence and who demonstrate their willingness to toilet at night. In our study, we attempted a nighttime toileting assistance program with 61 incontinent nursing home residents. Wetness rates remained relatively high at night—49%—while appropriate toileting rates were low—18%. Ideally, wetness rates should drop below 20% and appropriate toileting rates should be above 66%. The poorest response rate was primarily observed between 10 pm and 6 am. Even residents who responded well to daytime prompted voiding showed poor results at night.

Assign time-consuming tasks that are typically the responsibility of nurse aides to non-traditional care providers, including volunteers, social service staff, even administrative personnel, so that nurse aides have more time to provide prompted voiding. Some mealtime chores and between-meal snack deliveries, for example, can be handled by non-traditional staff. See our weight loss prevention module, especially step 3, for tips on redeploying staff at mealtimes.

REDUCE THE NUMBER OF HOURS DURING WHICH STAFF PROVIDE PROMPTED VOIDING.

Ideally, incontinent residents should be offered prompted voiding every two hours

between 7 am and 7 pm. Realistically? Between 8 am to 4 pm will do. With this schedule, residents will receive toileting assistance four times a day, enough to stay dry for the period. They are also more likely to receive the assistance they need because nursing homes are typically better staffed during the day shift than the evening and graveyard shifts.

RAISE THE APPROPRIATE TOILETING RATE TO MORE NARROWLY TARGET SERVICES.

As a last resort, use more restrictive criteria to target the prompted voiding intervention to the most responsive residents. Instead of using an appropriate toileting rate of 66% or higher, raise the rate to above 75%, for example. (*Step 2* explains how to calculate this rate.) This targeting approach, unfortunately, will exclude some residents who could benefit from prompted voiding. Nevertheless, despite this serious drawback, it is ethically and clinically preferable to providing sub-optimal assistance to all incontinent residents or targeting assistance based on invalid resident characteristics such as cognitive status, both of which are common practices in nursing homes.

A WORD OF CAUTION: DO NOT RESTRICT FLUIDS TO IMPROVE CONTINENCE.

Some residents will purposely restrict their fluid intake in an attempt to improve their continence. For the same reason, some nursing homes will do the same for residents. In both cases, it's a bad idea, potentially harmful to a resident's health. Studies show that the majority of nursing home residents are at high risk for dehydration, a condition associated with

numerous adverse clinical outcomes for residents, including the ultimate: death (4).

Far from an opportune time to limit fluids, the start of a prompted voiding program is the ideal time to offer *extra* fluids to residents. Incontinent residents may be more likely to drink more if they know they can count on help to the toilet. And it will take staff next to no extra time to offer the extra care because they have to attend to the residents in any case.

Experts recommend that nursing home staff offer *all* residents extra fluids between meals, as many as 4-8 times a day. For more information about strategies to increase residents' fluid intake, visit our training module on weight loss preventions, especially the *FAQs*.

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Step 4: Monitor the Prompted Voiding Program

Conduct periodic control checks to monitor the prompted voiding program and ensure quality of care. Share results with nurse aides to elicit their help with improvement efforts and strengthen their commitment to the program.

CONTINUOUS QUALITY ASSESSMENTS HELP ENSURE PROGRAM SUCCESS

Having accomplished Steps 1 (*basic evaluation*), 2 (*prompted voiding trial*), and 3 (*program implementation*), your facility now has a significant investment in improving the quality of incontinence care for residents. All that time and money may go to waste, however, unless supervisors conduct regular “wet” checks to make sure nurse aides continue to provide quality care. Most nursing homes forego this step only to pay a price for their negligence: studies show that in the absence of quality control assessment, nurse aides backslide and fail to consistently implement prompted voiding with incontinent residents (1).

Evidently, old habits are hard to break and new ones are hard to maintain if you don't get timely feedback about how you're doing, including reinforcement for doing things right and recommendations for improvement if you're doing things wrong. This feedback loop is a hallmark of continuous quality improvement programs. Commenting on the proven effectiveness of these programs, geriatrician John Morley and his colleagues observe (2): “It does not take the wizardry of Harry Potter to curb errors, but rather the ‘magic’ of data collection, analysis, and self-correction in a timely way (2003; pg. 809).” Step 4 is all about this kind of magic.

CONDUCT WET CHECKS

Quality monitoring starts with conducting quality control checks—also called wet checks. This is a four-step task that takes about 15-20 minutes per week:

Weekly Wet Check Procedure

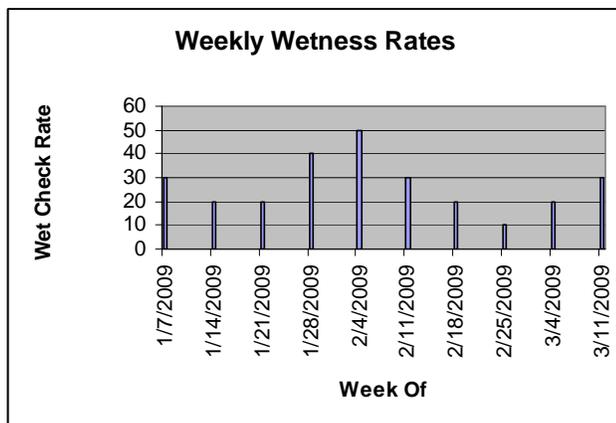
1. Once a week, a supervisory nurse should check a random sample of at least 10 prompted voiding residents for wetness. How do you identify a random sample? Write the names of each prompted voiding resident on a slip of paper, put all the slips in a hat, and pull 10. Make sure the wet checks are unpredictable. Don't, for example, always conduct them on the same day at the same time.
2. Record wet check results on our Wet Check Record.
3. Use the results to calculate a weekly wetness rate. For example, if two of the 10 residents are found wet, then the wetness rate for that week is 20%.
4. Report the results to CNAs. A 5-minute stand-up meeting will do. As a general rule, if the wetness rates exceeds 30% (that is, if 4 or more of the 10 residents are wet or soiled), then the prompted voiding program is not working as expected. Ask CNAs for improvement recommendations. If the wetness rate is 30% or lower, congratulate them on a job well done.

OPTIONAL: CUSTOMIZE WET CHECKS

You can fine tune wet checks by calculating a Wet Check Warning Limit that takes into account the toileting rates of the residents in your facility. In the above, general procedure, we used a 30% wetness rate at the default Wet Check Warning Limit. In fact, however, depending on your residents, a higher or lower warning limit may be more appropriate. We won't go into the statistical rules used to calculate a customized Wet Check Warning Limit. There's no need, for we created an Excel program that will do those calculations for you. You can download that program and the 3-step instructions for using it on our website.

TRACK PERFORMANCE OVER TIME

For best results, keep track of the wet check results over time. A visual chart of results will help you spot patterns easily.



Is performance improving? Staying the same? Declining? In the example above, the wet-check pattern suggests the prompted voiding program is working as expected, with an exception for a two-week period starting the week of 1/28/09. If high wetness rates become a frequent or consistent problem, further analysis is need. Consider, for example, whether out-of-control results indicate a change in a

resident's status, a breakdown in care during shift changes, or a staffing problem on a particular hallway. All these are common occurrences that can skew program results.

Over the course of several weeks, as prompted voiding becomes routine for the staff and residents, you should see consistent wet check results. After several months of consistent results, you can consider conducting random wet checks bi-weekly. But don't stop them! In addition to the performance feedback they provide, the wet checks send a message to CNAs that the facility values high quality incontinence care. This helps keep motivation levels high.

SHARE RESULTS WITH STAFF, ELICIT THEIR HELP WITH IMPROVEMENTS

This step bears repeating, for to truly experience the "magic" of continuous quality improvement, you must share wet check results with the CNAs who perform the lion's share of the work for the prompted voiding program. As we noted at the start of this step, staff members need feedback—both good and bad—to help them establish new work routines. Simply posting an updated control chart each week, for example, will enable nurse aides to make connections between their work and the impact it has on their residents. If CNAs can see tangible evidence of the prompted voiding program's benefits, then they are less likely to view the intervention as an additional burden and more likely to work to sustain its positive effects.

Sharing performance results also gives nurse aides the opportunity to help supervisors correct any problems that arise. Often the aides are the first to know if a resident's status has changed or if there's

been a break-down in the work process. Involving these staff members in improvement efforts will also help strengthen their commitment to the program.

In addition to posting control charts, you can present wet check results at in-service trainings and regular staff meetings. A 5-minute stand-up meeting once a week focused specifically on incontinence care is effective for training and management purposes.

Consider rewarding the staff for consistently good results. The most powerful motivators are job advancements and salary increases. If these are beyond your budget, a staff pizza party every quarter for outstanding performance can't hurt.

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QUIZ

Instructions: Check the best answer.

1. **In order to stay dry, incontinent residents need toileting assistance how often within a 12-hour period?**
 - a. ____ 1-2 times
 - b. ____ 3-4 times
 - c. ____ 5-6 times
 - d. ____ 7-8 times
2. **On average, how often is toileting assistance usually offered during the daytime to incontinent nursing home residents?**
 - a. ____ Less than once during the day
 - b. ____ 1-2 times
 - c. ____ 3-4 times
 - d. ____ 5-6 times
3. **Which of the following has been shown to significantly improve continence?**
 - a. ____ Scheduled toileting
 - b. ____ Prompted voiding
 - c. ____ Habit training
 - d. ____ Use of diapers
4. **Prompted voiding works by:**
 - a. ____ Encouraging residents to ask for toileting assistance.
 - b. ____ Offering toileting assistance every two hours during the daytime.
 - c. ____ Heightening residents' awareness of their continence status.
 - d. ____ All of the above.
5. **A resident's responsiveness to prompted voiding can best be determined based on a:**
 - a. ____ Functional performance test
 - b. ____ Cognitive performance test
 - c. ____ Brief trial of prompted voiding
 - d. ____ Any one of the above tests or trials
6. **Residents who prove responsive to prompted voiding will use the toilet appropriately:**
 - a. ____ Less than a third of the time
 - b. ____ About half the time
 - c. ____ More than two-thirds of the time
 - d. ____ Always
7. **Which of the following strategies can make it more feasible for facilities to provide prompted voiding?**
 - a. ____ Forego offering prompted voiding at nighttime
 - b. ____ Integrate prompted voiding with interventions that enhance residents' mobility
 - c. ____ Reduce the number of daytime hours during which prompted voiding is offered
 - d. ____ All of the above

8. If your facility fails to monitor its prompted voiding program, then:

- a.____ Federal surveyors may cite your facility.
- b.____ Nurse aides may stop implementing the prompted voiding protocol consistently.
- c.____ Residents will lose their ability to use the toilet appropriately.
- d.____ All of the above.

9. The purpose of a control chart is to:

- a.____ Compare a resident's preferences for toileting assistance to the amount of toileting assistance actually provided.
- b.____ Compare the number of times a resident toileted appropriately to the number of times the resident was asked to toilet.
- c.____ Compare the percentage of residents found wet at any given time to the percentage who should be wet if the prompted voiding program is working as expected.
- d.____ Compare the incidence of incontinence in a given facility to the incontinence incidence in all other nursing homes.

10. Sharing the results of wet checks with your nurse aides can:

- a.____ Elicit their suggestions for resolving any problems that may arise in the prompted voiding program.
- b.____ Help aides see a tangible connection between the work they do and the well-being of residents.
- c.____ Motivate the aides to consistently implement the prompted voiding protocol.
- d.____ All of the above.

Answers: 1. b; 2. a; 3. b; 4. d; 5. c; 6. c; 7. d; 8. b; 9. c; 10. d

Frequently Asked Questions

Do the Minimum Data Set (MDS) urinary incontinence quality indicators show that some nursing homes provide better incontinence care?

In a recent study conducted in 14 nursing homes, we collected independent data that showed that the only two currently used MDS incontinence quality indicators (QIs)- "prevalence of incontinence" and "prevalence of incontinence without a toileting plan"-do not reflect real differences in the quality of incontinence care provided to residents (1). None of the facilities, for example, evaluated residents' responsiveness to toileting assistance (see Step 2 for instructions on how to do this). Residents who received toileting assistance were comparatively less cognitively and physically impaired, which suggests that staff used invalid resident characteristics to determine who received services. Although facilities with better scores on both MDS incontinence QIs were more likely to document in medical records that residents received toileting assistance, there were no difference between homes in resident reports of the assistance they actually received. Across all facilities, participants capable of accurately reporting care activity said they received an average of 1.8 toileting assists per day (range 1.6-2.0), which is insufficient to improve urinary incontinence. There also were no differences in reports of received assistance between residents noted in the MDS as being on scheduled toileting and those who were not. This finding points to disturbing discrepancies between care documented and care actually provided.

Is prompted voiding an effective intervention for reducing nighttime urinary incontinence?

The short answer is no. In the only study of its kind (2), we attempted a nighttime toileting assistance program with 61 incontinent nursing home residents. Wetness rates remained relatively high at night-49%--while appropriate toileting rates were low-18%. Ideally, wetness rates should drop below 20% and appropriate toileting rates should be above 66%. Even residents who responded well to daytime prompted voiding showed poor results at night. Prompted voiding is effective with most residents between 7:00 am and 10:00 pm. However, there are some residents who want to use the toilet during the night, and who can maintain dryness if given assistance.

Based on these findings, we recommend that nighttime incontinence care be individualized, with the goals of minimizing sleep disruption and protecting at-risk residents from skin problems. Prompted voiding and other toileting assistance interventions should be reserved for those residents who are bothered by nighttime incontinence and who demonstrate, through a two- or three-night trial, their willingness to toilet at night. (See Step 2 for procedures for conducting prompted voiding trials.)

In a related study (3), our research staff individualized nighttime incontinence care by conducting hourly rounds in four nursing homes and providing incontinence care only if participating residents were found awake during the round. Residents at low risk for skin problems were allowed to sleep for as many as four consecutive hourly checks, but were awakened on the fifth if asleep. Residents at high risk for skin problems were allowed to sleep for only two

consecutive hourly checks and awakened on the third if asleep. There were no adverse, intervention-related changes in skin health or most other risk factors associated with skin. The intervention also proved no more labor intensive to provide than usual care.

We also recommend a noise and light abatement program to facilitate nighttime sleep. These programs feature common sense procedures such as closing doors to residents' rooms, fixing squeaky equipment, turning off unattended TVs and radios, and using table lamps instead of overhead lights when providing incontinence care.

What treatments for urinary incontinence do family members prefer?

To find out, we surveyed three groups of respondents: frail older adults, family members of nursing home residents, and long-term-care nursing staff (4). Among all respondents, 85% "definitely" or "probably" preferred diapers, and 77% "definitely" or "probably" preferred prompted voiding to indwelling catheterization. There were, however, differences among the respondent groups. Nurses preferred prompted voiding to diapers more than did older adults or family members. Older adults, compared with family and nurse respondents, more strongly preferred medications to diapers. In open-ended responses, older adults (nine of them nursing home residents and 70 residential care residents) said they would choose a treatment based in part upon criteria of feeling dry, being natural, not causing embarrassment, being easy, and not resulting in dependence. The comments also indicated that older adults and families did not believe nursing home staff would provide prompted voiding often enough to improve continence (see Step 3 for time-saving strategies that help maintain prompted voiding programs). Because of the

divergence of opinions among different proxy respondents, we recommend that, when possible, nursing home residents be asked first for their treatment preference.

Some of our incontinent residents purposely restrict their intake of fluids to try to prevent wet episodes. Is this recommended?

No. Restricting fluids in an attempt to improve continence is potentially harmful to a resident's health. Studies show that the majority of nursing home residents are at high risk for dehydration, a condition associated with numerous adverse clinical outcomes for residents, including the ultimate: death (5).

Experts recommend that nursing home staff offer all residents extra fluids between meals, as many as 4-8 times a day (5). Incontinent residents may be more likely to drink more if they know they can count on help to the toilet. For this reason, we believe the start of a prompted voiding program is an ideal time to begin offering extra fluids to residents (see our introduction to this training module). Consider offering residents beverages to drink before or after assisting them to the toilet.

For more information about strategies to increase residents' fluid intake, visit our training module on weight loss prevention, especially the FAQs.

Many of our residents suffer from constipation and fecal incontinence. Will a prompted voiding program help them?

Possibly, but only if prompted voiding is combined with interventions that increase mobility/exercise and prompt residents to drink more. When this type of integrated intervention is implemented, there is evidence that there will be a major increase

in how often residents have a bowel movement in the toilet and a decrease in the frequency of incontinent bowel movements. Our training module on mobility decline prevention describes such an intervention. Constipation, however, remains a problem. Other intervention components will likely have to be included in a comprehensive program to improve constipation. Improving food intake and controlling medications with constipative side effects are two treatments that should supplement prompted voiding.

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Related Studies

Predictors of Successful Prompted Voiding Among Incontinent Nursing Home Residents.

Joseph G. Ouslander, John F. Schnelle, Gwen Uman, Susan Fingold, Jennifer Glater Nigam, Edward Tuico, Barbara Bates-Jensen, 1995, in *Journal of the American Medical Association*, 273(17):1366-1370.

This report describes a simple, noninvasive assessment strategy that enables nursing home staff to identify incontinent residents who respond well to prompted voiding. Of the 191 residents in seven nursing homes who completed the demonstration trial, 41% were deemed responsive to the intervention. On average, their wet episodes dropped from 8.7 to 2.0 per day as a result of the intervention, during which research staff prompted them to use the toilet every two hours between 7 am and 7 pm.

The best predictors of responsiveness were the number of wet episodes and the appropriate toileting rate during the first three days of the trial. Residents who appropriately toileted 66% or more of the time or who were found wet on 20% or fewer daily checks maintained improved continence for an additional nine weeks of prompted voiding. The researchers recommend that nursing homes implement the three-day "run-in" trial to identify residents who are most responsive to prompted voiding. "Responders" should continue to receive toileting assistance, while the non-responders should be considered for further evaluation and alternative interventions.

Translating Clinical Research into Practice: A Randomized Controlled Trial of Exercise and Incontinence Care with Nursing Home Residents.

John F. Schnelle, Cathy A. Alessi, Sandra F. Simmons, Nahla R. Al-Samarrai, John C. Beck, Joseph G. Ouslander, 2002, in *Journal of the American Geriatrics Society*, 50:1476-1483.

An incontinence care and exercise intervention called FIT, for Functional Incidental Training, resulted in significant improvements in physical mobility and continence for most residents who received the intervention. The staffing requirements needed to implement the intervention, however, are high and exceed the resources available in most nursing homes.

In this randomized, controlled trial, research staff prompted each of 94 intervention residents to toilet every two hours, five days a week, between 8 am and 4:30 pm. Before or after providing incontinence care, staff encouraged the residents to walk or, if non-ambulatory, to wheel their chairs and to repeat sit-to-stands up to eight times. Once a day, each resident was given upper body resistance training. Before and after each care episode, staff offered fluids to residents. After 32 weeks of FIT, intervention residents maintained or improved performance on 14 of 15 outcome measures, whereas the performance of the 96 residents in the control group declined.

The mean time required to implement the intervention each time care was provided was 20.7 minutes. Consequently, one nurse aide for every five residents would be needed to implement the intervention. Less than 10% of the nation's nursing homes are staffed at this level. The researchers conclude, "Fundamental changes in the staffing of most nursing homes will be necessary to translate efficacious clinical interventions into everyday practice."

Incontinence

John F. Schnelle, in *Comprehensive Clinical Psychology*. Bellack AS, Hersen M. (Eds.) Pergamon, NY. 1998; 433-454.

This chapter describes the prevalence of urinary incontinence among older adults, discusses treatment options, and presents detailed guidelines for assessing and managing urinary incontinence among nursing home residents. Particular attention is paid to prompted voiding programs, the most extensively evaluated toileting assistance program for nursing home residents. The role behavioral healthcare professionals can play in assessing and managing incontinence is highlighted. The author also identifies areas related to incontinence treatment that need further study.

The Minimum Data Set Urinary Incontinence Quality indicators: Do They Reflect Differences in Care Processes Related to Incontinence?

John F. Schnelle, Mary P. Cadogan, June Yoshii, Nahla R. Al-Samarrai, Dan Osterweil, Barbara M. Bates-Jensen, and Sandra F. Simmons, 2003, in *Medical Care*, 41(8):909-922.

Federal regulations require nursing homes to complete resident assessments periodically using the Minimum Data Set (MDS) assessment protocol. Results are used to generate quality indicators (QI) for each facility as a means of identifying poor outcomes in a number of clinical areas. But the use of QIs as a measure of quality of care is controversial due in part to concerns about the accuracy of staff-generated MDS data.

This study, conducted in 14 nursing homes, collected independent data that showed that the only two currently used MDS incontinence QIs--"prevalence of incontinence" and "prevalence of incontinence without a toileting plan"--do not reflect real differences in the quality of incontinence care provided to residents.

None of the facilities, for example, evaluated residents' responsiveness to toileting assistance. Residents who received toileting assistance were comparatively less cognitively and physically impaired, which suggests that staff used invalid resident characteristics to determine who received services. Although facilities with better scores on both MDS incontinence QIs were more likely to document in medical records that residents received toileting assistance, there were no difference between homes in resident reports of the assistance they actually received. Across all facilities, participants capable of accurately reporting care activity said they received an average of 1.8 toileting assists per day (range 1.6-2.0), which is insufficient to improve urinary incontinence. There also were no differences in reports of received assistance between residents noted in the MDS as being on scheduled toileting and those who were not. This finding points to disturbing discrepancies between care documented and care actually provided.

Urinary Incontinence Treatment Preferences in Long-Term Care.

Theodore M. Johnson, Joseph G. Ouslander, Gwen C. Uman, and John F. Schnelle, 2001, in *Journal of the American Geriatrics Society*, 49:710-718.

What treatments for urinary incontinence are preferred for nursing home residents? This study asked this question of frail older adults, family members of nursing home residents, and long-term-care nursing staff. Among all respondents, 85% "definitely" or "probably" preferred diapers, and 77% "definitely" or "probably" preferred prompted voiding to indwelling catheterization. There were, however, differences among the respondent groups. Nurses preferred prompted voiding to diapers more than did older adults or family members. Older adults, compared with family and nurse respondents, more strongly preferred

medications to diapers. In open-ended responses, older adults (nine of them nursing home residents and 70 residential care residents) said they would choose a treatment based in part upon criteria of feeling dry, being natural, not causing embarrassment, being easy, and not resulting in dependence. The comments also indicated that older adults and families did not believe nursing home staff would provide prompted voiding often enough to improve continence. Because of the divergence of opinions among different proxy respondents, the researchers recommend that, when possible, nursing home residents be asked first for their treatment preference.

Strategies to Measure Nursing Home Residents' Satisfaction and Preferences Related to Incontinence and Mobility Care: Implications for Evaluating Intervention Effects.

Sandra F. Simmons and John F. Schnelle, 1999, in *The Gerontologist*, 39(3):1-11.

This study compared four different interview strategies to measure 111 incontinent nursing home residents' "met need" related to incontinence and mobility care. In one method—perhaps the most commonly used strategy in nursing homes—residents were asked direct satisfaction questions (e.g., "Overall, are you satisfied with how often someone helps you to walk?"). A second method asked residents about their preferences for care (e.g., "Would you like for someone to help you walk more often?" "How many times during the day would you like someone to help you to walk?") The last two methods compared resident reports about how often they preferred to receive care to how often they actually did receive care based first on research staff observations (Method 3) and then on their own reports (Method 4). Incontinent residents who passed a simple cognitive

screen (residents were asked to state their name or identify two common items) were interviewed.

Results showed that only 25% of the residents provided illogical responses, a finding that dispels the widespread assumption that only a small subset of cognitively intact residents can provide meaningful information about the care they receive. Of the four methods tested, the third method proved superior with respect to response stability. Method 1 yielded the most unstable responses. The third method also revealed comparatively higher levels of "unmet need," but by doing so, is considered more useful for guiding improvement efforts. The authors acknowledge that Method 3 is the most time-consuming to implement because it requires objective, direct observations of the care actually provided to residents. They argue, however, that this type of monitoring should be conducted at least annually in any case.

A Cost and Value Analysis of Two Interventions with Incontinent Nursing Home Residents.

John F. Schnelle, Emmett Keeler, Ron D. Hays, Sandra Simmons, Joseph G. Ouslander, and Albert L. Siu, 1995, in *Journal of the American Geriatrics Society*, 43:1112-1117.

In this study, family members of nursing home residents and older board-and-care residents were asked in a written survey to compare the value of interventions that improve continence and mobility to other nursing home perks such as improved meals or moving to a more private room. By wide margins, the respondents rated the functional improvement programs higher than the other, more customary options. The top-rated programs were a physical therapy program that provides 15 additional minutes of supervised activity and exercise a day, an incontinence prevention program that cuts the number of wetness episodes in half for a resident, and a program that improves the

amount a resident can walk by a few minutes a day. These services were significantly preferred to any of the bottom-rated, non-rehabilitative services, which included having one additional nurse aide on the unit during the day shift, moving from a triple room to a single, from a triple room to a double, and from double room to a single. The researchers point out that while nursing home consumers often complain about privacy and food issues, they rarely request services that improve continence and walking, most likely because they are unaware of such rehabilitative programs.

Prompted Voiding for Nighttime Incontinence in Nursing Homes: Is it Effective?

Joseph G. Ouslander, Nahla Al-Samarrai, and John F. Schnelle, 2001 in *Journal of the American Geriatrics Society*, 49:706-709.

Does prompted voiding improve continence at night? No, not according to this study, which attempted a nighttime toileting assistance program with 61 incontinent nursing home residents. Wetness rates remained relatively high at night-49%--while appropriate toileting rates were low-18%. Ideally, wetness rates should drop below 20% and appropriate toileting rates should be above 66%. Even residents who responded well to daytime prompted voiding showed poor results at night. The researchers recommend that night care be individualized, with the goals of minimizing sleep disruption and protecting at-risk residents from skin problems. Prompted voiding and other toileting assistance interventions should be reserved for those residents who are bothered by nighttime incontinence and who demonstrate, through a two- or three-night trial, their willingness to toilet at night.

Individualizing Nighttime Incontinence Care in Nursing Home Residents.

John F. Schnelle, Patrice A. Cruise, Cathy A. Alessi, Nahla Al-Samarrai, Joseph G. Ouslander, 1998, in *Nursing Research*, 47(4):197-204.

An intervention that combined individualized nighttime incontinence care with a noise and light abatement program significantly reduced awakenings among 92 residents in four nursing homes. The intervention was developed in response to findings from an earlier nursing home study that found that 42% of nighttime waking episodes lasting four minutes or longer were associated with noise, light, or incontinence care activities.

For the intervention, incontinent residents were first assessed to determine their risk of developing skin problems. Nurses conducted hourly incontinence rounds and provided incontinence care only if a resident was found awake during the round. Residents at low risk for skin problems were allowed to sleep for as many as four consecutive hourly checks, but were awakened on the fifth if asleep. Residents at high risk for skin problems were allowed to sleep for only two consecutive hourly checks and awakened on the third if asleep.

The noise and light abatement program centered on common sense procedures such as closing doors to residents' rooms, fixing squeaky equipment, turning off unattended TVs and radios, and using table lamps instead of overhead lights when providing incontinence care. There were no adverse, intervention-related changes in skin health or most other risk factors associated with skin. The intervention also proved no more labor intensive to provide than usual care.

The Use of a Computer-Based Model to Implement an Incontinence Management Program.

John F. Schnelle, Patrick McNees, Valerie Crooks, and Joseph G. Ouslander, 1995, in *The Gerontologist*, 35(5):656-665.

A computerized total quality management model was used to implement a prompted voiding incontinence intervention in eight nursing homes. Research staff measured resident wetness for one month, provided training in the implementation of the program in less than five days, and measured resident wetness for six months. Seven of the eight nursing homes significantly improved resident dryness for a six-month period. However, objective improvement in resident dryness was not a sufficient incentive for nursing home staff to maintain the program; extensive monitoring of the nursing home computers by modem and telephone feedback from the research staff was necessary to produce successful maintenance. The researchers cite frequent staff turnover in nursing homes as one impediment to maintaining the intervention. Lack of positive feedback for improved outcomes from both external surveyors and the residents themselves may also explain why nursing home staff backslide into old care routines.

Related Links and Resources

- American Foundation for Urologic Disease
- National Institute of Diabetes and Digestive and Kidney Diseases
- National Institute on Aging
(www.nia.nih.gov/)
- National Kidney and Urologic Diseases Information Clearinghouse
(kidney.niddk.nih.gov/about/index.htm)
- Simon Foundation for Continence
(www.simonfoundation.org/html/)

Incontinence Management Forms

FORMS FOR STEP 2—CONDUCTING A PROMPTED VOIDING TRIAL

- Toileting Motivation and Preference Assessment Survey
- Prompted Voiding Trial

FORMS FOR ASSESSING INCONTINENCE QUALITY INDICATORS—USE BOTH FORMS TOGETHER

- Medical Record Review
- Quality Indicator Data Sources and Scoring Rules
- Wet Check Record

QUALITY INDICATORS FOR INCONTINENCE CARE

We worked with researchers at RAND, a southern California think tank, to develop a series of nine quality indicators (QI) related to incontinence care for nursing home residents. Presented as a series of if/then statements, these QIs outline minimally acceptable care for the assessment and treatment of incontinent residents. QIs, writes RAND, “set a minimal standard for acceptable care—standards that, if not met, almost ensure that the care is of poor quality.”

Based on expert opinion and existing best-practice guidelines, all of our QI-associated assessment and treatment tasks are *both* related to positive outcomes for residents *and* feasible for nursing home staff to implement. Use the two QI forms listed at the left to evaluate incontinence care in your facility.

STEP 2: PROMPTED VOIDING TRIAL

Instructions: Use this form to record results of wet checks and prompted voiding attempts with *one* resident for *one* day of the assessment trial. Each resident should receive prompted voiding every two hours between 8 am and 4 pm, for a total of 4 times on each day of the assessment trial. There is space below to record results for 4 wet checks and prompted voiding attempts. You will need to complete 2 or 3 of these forms per resident depending on whether the prompted voiding trial extends for 2 or 3 days.

Resident Name: _____ **Employee Name:** _____

Date: _____ **Day of Trial:** ___1st ___2nd ___3rd

Time: _____ at 1st check _____ at 2nd check _____ at 3rd check _____ at 4th check

1. Resident's condition at check (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Dry	Dry	Dry	Dry
Wet	Wet	Wet	Wet
Bowel	Bowel	Bowel	Bowel
Wet and bowel	Wet and bowel	Wet and bowel	Wet and bowel

2. Toileting outcome (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Refused	Refused	Refused	Refused
Dry run*	Dry run	Dry run	Dry run
Urine	Urine	Urine	Urine
Bowel	Bowel	Bowel	Bowel
Urine and bowel	Urine and bowel	Urine and bowel	Urine and bowel

* A "dry run" means that the resident attempted to toilet but failed to void.

3. Resident's reaction to checks and prompts (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Self-initiates	Self-initiates	Self-initiates	Self-initiates
Cooperates-neutral	Cooperates-neutral	Cooperates-neutral	Cooperates-neutral
Cooperates-reluctant	Cooperates-reluctant	Cooperates-reluctant	Cooperates-reluctant
Uncooperative	Uncooperative	Uncooperative	Uncooperative

4. Level of assistance resident needed to toilet (circle one for each check):

1st check:	2nd check:	3rd check:	4th check:
Independent	Independent	Independent	Independent
Stand-by asst.	Stand-by asst.	Stand-by asst.	Stand-by asst.
Needs help of 1 person			
Needs help of 2 persons			

ANALYZE RESULTS

When the prompted voiding trial is complete, calculate the following for each resident:

- Appropriate toileting rate: Divide the total number of successful toilets by the total number of toileting attempts, typically 8 for a two-day trial or 12 for a three-day trial. Multiply the quotient by 100 for a percentage.

Use this chart to guide interpretation of results:

- 76%-100% Excellent ability to toilet
- 66%-75% Good ability to toilet
- 50%-65% Fair ability to toilet
- 0%-49% Poor ability to toilet

Residents with an appropriate toileting rate above 66% should continue to receive prompted voiding.

Residents with appropriate toileting rates below 66% seldom show responsiveness with longer term applications of prompted voiding. Treatment options for these “non-responders” should be based on their pre- and post-trial answers to the *Toileting Motivation and Preference Assessment questions* (see our Forms page for this survey instrument) and their behavior during the trial.

Non-responsive residents who express a willingness to improve continence should be further evaluated to identify all problems that are potentially treatable by other interventions. As a general rule, any resident who attempts to toilet two times a day, even if unsuccessfully, should be considered motivated to stay dry and should thus receive a follow-up evaluation and after that, another prompted voiding trial.

About 10%-20% of non-responders will show no willingness to improve continence. In interviews, they express no desire to be either changed or toileted more frequently. In prompted voiding trials, they show or verbalize that toileting assistance is unwanted. These residents should be placed on a check-and-change program. No research findings to date suggest that other treatments will be more successful.

- Wet rate: Divide the total number of checks on which the resident was found wet by the total number of checks, then multiply by 100 to convert to a percentage. Use the wet rate to help construct a control chart for monitoring the prompted voiding program (see Step 4 of the incontinence management training module).

Calculate the resident’s “average” reaction to checks and prompts and his or her “average” level of assistance needed to toilet to create a profile that can help you develop an appropriate plan of care for the resident.

Medical Record Review Form

MEDICAL RECORD REVIEW FORM					
	Location of data in Medical Record	YES	NO/N D	DATE (If YES)	Comments
SCREENING FORM (ALL RESIDENTS)					
1. Was the presence or absence of urinary incontinence documented at admission? ("Yes" if Licensed Nurse documents within 2 weeks and/or MD documents within 1 month)	<u>Admission Nursing Assessment</u> Or <u>Admission H&P</u> (MD, NP)				If yes, check all that apply: <input type="checkbox"/> Licensed Nurse documented UI <input type="checkbox"/> Licensed Nurse documented no UI <input type="checkbox"/> MD documented UI <input type="checkbox"/> MD documented no UI <input type="checkbox"/> Indwelling catheter documented
2. Did the resident have an indwelling catheter?					If yes, was a reason stated? <input type="checkbox"/> NO <input type="checkbox"/> YES _____
3. Urinary Incontinence RAP triggered? (MDS Form)					
4. MDS H1b = 2 or 3 (Occasionally or Frequently Incontinent)					
5. MDS H1b = 4 (Multiple, daily incontinent episodes)					
6. MDS H3a (scheduled toileting plan) ^{vd} OR H3b (Bladder retraining Program) ^{vd}					If yes, circle item (s) ^{vd} H3a H3b
7. MDS G1i>0 (toileting assistance)					If yes, circle score: 1 2 3 4
TARGETED INCONTINENCE REVIEW					
8. Were any of the following done within 1 month after UI identified?					
a. Mental status evaluation	Nurse Assessment, <u>Progress notes</u> (MD, Nurse)				
b. Characteristics of voiding	Nurse Assessment, <u>Progress notes</u> (MD, Nurse)				
c. Ability to get to the toilet	Nurse Assessment, <u>Progress notes</u> (MD, Nurse, PT)				
d. Prior treatment for incontinence	<u>Progress notes</u> (MD, Nurse)				

e. Importance of problem to resident	<u>Progress notes</u> (MD, Nurse, Psychologist)				
f. Rectal Exam	Admit H & P, <u>Progress notes</u> (MD, NP, Nurse)				Accept documentation of bowel moves if in primary provider notes for a rectal exam:
g. Genital/pelvic Exam	Admit H & P, <u>Progress notes</u> (MD, NP)				
h. Skin Exam	Nurse Assessment, Admit H & P, <u>Progress notes</u> (MD, Nurse)				
i. Dipstick urinalysis	LAB				
j. Post-void residual	<u>Progress notes</u> (Nurse, MD)				
<u>k. 24 hour voiding record</u>	C.N.A. or Licensed Nurse Notes or Nurse Assessment				
9. Was a 3-5 day toileting assistance trial done?	C.N.A. Flowsheet or Licensed Nurse notes or Nurse Assessment				If YES, Answer Q 10 – 11 If NO, Answer Q 11 <i>Accept any description of toileting assistance trial even if no note about outcomes is made</i>
10. During the trial, was the resident capable of using the toilet appropriately over 65% of the time?	C.N.A. Flowsheet or licensed RN notes or RN assessment				
11. Was resident placed on a toileting assistance program?	MD Orders <u>Progress notes</u> (Licensed Nurse, MD) C.N.A. flowsheet				Accept documentation of toileting program even if specific frequency is not noted (e.g., “toileting as needed”

URINARY INCONTINENCE - Quality indicator data sources and scoring rules

Quality Indicator	Data Source and Scoring Rules
<p>1. ALL N. Home Residents should have documentation of the presence or absence of urinary incontinence (UI) at the time of admission.</p>	<p><i>Medical Record</i> screening form #1 Scoring <i>PASS:</i> screening form urinary incontinence #1 √/d "yes"</p>
<p>2. IF a N. Home Resident has UI on admission or the new onset of UI that persists for over 1 month, THEN a targeted history should be obtained that documents each of the following:</p> <ul style="list-style-type: none"> • Mental status, • Characteristics of voiding, • Ability to get to toilet, • Prior treatment for urinary incontinence, and • Importance of the problem to the resident. 	<p>Medical Record IF = screen form #4 or #5 is "yes" THEN = #8a - e Scoring <i>PASS:</i> at least 2 of items #8a - e √/d "yes"</p>
<p>3. IF a N. Home Resident has new UI that persists for over 1 month or UI on initial assessment, THEN a targeted physical should be performed that documents:</p> <ul style="list-style-type: none"> • Rectal exam, • Skin exam, and • Genital system exam (including a pelvic exam for women). 	<p>Medical Record IF = screen form #4 or #5 is "yes" THEN = #8f - h Scoring <i>PASS:</i> all of the items #8f - h √/d "yes"</p>
<p>4. IF a N. Home Resident has new UI that persists for over 1 month or UI on initial assessment, THEN the following tests should be obtained or there should be documentation explaining why the test was not completed:</p> <ul style="list-style-type: none"> • Dipstick urinalysis, • Post void residual, and 24 hour voiding record. 	<p>Medical Record IF = scoring form #4 or #5 is yes THEN = #8l - k Scoring <i>PASS:</i> at least 2 of items #8l - k √/d "yes"</p>
<p>5. IF a N. Home Resident remains incontinent after transient causes are treated, THEN the resident should be placed on a 3 to 5 day toileting assistance trial.</p>	<p>Medical Record IF = scoring form #4 or #5 is "yes" THEN = #9 Scoring <i>PASS:</i> urinary incontinence checklist #9 √/d "yes"</p>
<p>6. IF a N. Home Resident who is incapable of independent toileting is found on a toileting assistance trial to be capable of appropriately using the toilet over 65% of the time, THEN the resident should be placed on a toilet assistance program.</p>	<p>Medical Record IF = urinary incontinence checklist #7 and #9 are "yes" THEN = #10 Scoring <i>PASS:</i> items #10 and #11 √/d "yes" <i>Not applicable</i> when #10 √/d "no"</p>

<p>7. IF the MDS documents that a resident's self-performance of toileting is level 1 (supervision), level 2 (limited assistance), level 3 (extensive assistance) or level 4 (total dependence),</p> <p>THEN the resident should be offered assistance with toileting:</p> <ul style="list-style-type: none"> • every 2 hours while awake or • a schedule based on formal need assessment (24 hour voiding record or pad test), or • whenever requested. 	<p>Medical Record + Interview IF = #7 is "yes"</p> <p>THEN = check #11 and ask preference questions</p> <p>Interview Preference Questions How many times would you like toileting assistance during the day? How many times do you receive toileting assistance during the day?</p> <p>Scoring A- Interview <i>PASS:</i> If the answer to question (the # of times during the day staff helps resident use toilet) is greater than or equal to the answer to question (the # of times during the day the resident would like to be helped to use the toilet)</p> <p>Scoring B-Medical Record <i>PASS:</i> #11 √/d "yes"</p>
<p>8. IF the MDS documents that a resident's self-performance of toileting is level 1 (supervision), level 2 (limited assistance), level 3 (extensive assistance) or level 4 (total dependence), or the resident or proxy reports needing assistance with toileting,</p> <p>THEN the resident should report that they receive verbal notification or cueing before the assistance is given, are not rushed to complete the task and are not afraid to request assistance when needed.</p>	<p>Interviewer : If #7 "yes" THEN ask: Are you afraid to ask the staff to help you use the toilet?</p> <p>Scoring: <i>PASS</i> if the answer is "no"</p>
<p>9. IF the N. Home Resident or proxy reports requesting assistance with any ADL (toileting),</p> <p>THEN the resident should report that s/he is satisfied with the timeliness of staff response to their request.</p>	<p>Interviewer: If resident reports they ask for assistance THEN ask: Do you have to wait a long time for them to help you?</p> <p>Scoring: <i>PASS</i> if answer is "no"</p>

Weekly Random Wet Checks

Week of: _____

Randomly select 10 residents on the prompted voiding program and check them for wetness. Record results below.

Resident	Date	Day of Week	Time	Check (Dry, Wet, Bowel, B&B)

Wetness rate for the week: _____%

Report results to CNAs. If the wetness rate exceeds 30%, then the prompted voiding program is not working as expected. Ask CNAs for improvement strategies.