

# Fiscal, Clinical, and Regulatory Implications of Incontinence

## INCONTINENCE – WHAT IS YOUR

# NURSING HOME SPENDING?

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### IF YOU THINK THE COST OF INCONTINENCE CARE WITHIN THE NURSING HOME COMMUNITY IS MODERATE, THINK AGAIN

Incontinence, the involuntary loss of bladder or bowel control, is an eight billion dollar a year industry that impacts 48% of nursing home residents nationwide. This data excludes residents with severe dementia and severe physical handicaps.<sup>1</sup> The National Institute on Aging estimates that more than 20 million Americans are incontinent and that incontinence is one of the leading causes of nursing home admissions.<sup>2</sup> Clearly it is in the best interest of nursing homes throughout the country to master the art of controlling costs associated with incontinence while remaining steadfast in achieving high quality care and dignity for the residents they serve.

### OVERVIEW

On a state-specific basis, the rate of incontinence in nursing homes varies from a low of 36% in Missouri to a high of 69% in Maine. In light of this data, nursing home decision makers should evaluate their percentage of incontinent residents and compare this statistic with that of other facilities in their state.

If the incontinence rate of a facility is significantly above the national average of 48%, data should be analyzed to determine why the facility is an “outlier.” All facilities, especially outlier facilities, must be sure that residents are being properly assessed.

### REGULATORY AND CORPORATE COMPLIANCE CONSIDERATIONS

It is incumbent upon nursing home decision makers to be familiar with current regulations, survey protocols, Centers for Medicare and Medicaid Services (CMS) requirements, and other relevant professional standards.

CMS, the administrative agency that oversees the Medicare and Medicaid programs for the federal government, revised surveyor guidance for “Incontinence and Catheters” on June 27, 2005. Recently, state surveyors received vigorous training by CMS in the revised guidelines and have begun to place a strong emphasis on incontinence prevention, assessment, and care during the survey process.

The intent of these revisions is to ensure that:

- Each resident who is incontinent of urine is identified, assessed, and provided appropriate treatment and services to achieve or maintain as much urinary function as possible.
- An indwelling catheter is not used unless there is medical justification.
- Services are provided to restore or improve bladder function to the extent possible, including after the removal of the catheter.
- A resident, with or without a catheter, receives the appropriate care and services to prevent infections to the extent possible.

Care plan development for incontinent residents with individualized interventions to enhance or maintain bladder control is also a key element in the CMS incontinence guidelines.

Examples of survey deficiencies issued to nursing facilities for providing deficient care to incontinent residents include:

- **F310:** Failure to implement a bladder training program for a resident with a decline in continence.
- **F311:** Staff members walked past a sleeping resident noted to have a strong urine odor, without providing intervention. Resident later claimed he or she often had to wait up to 30 minutes for staff to answer the call bell. The resident believed this resulted in “accidents,” causing him or her to become incontinent as a result. This resident was also noted to have developed a pressure ulcer.
- **F315:** Failure to document a medical rationale for the use of an indwelling catheter.
- **F272:** Failure to assess residents who were incontinent of urine for an individualized toileting program. There was no evidence that resident’s urinary status was assessed following the discontinuation of a Foley catheter. The facility failed to identify causative factors of incontinence or voiding patterns for a possible bladder retraining program. The urinary incontinence Resident Assessment Protocol (RAP) was not applied for a resident coded on the MDS as totally incontinent.
- **F281:** Facility staff failed to provide care and services in accordance with acceptable standards of practice as evidenced by failure to implement a bowel and bladder retraining program as per plan of care.

In light of the CMS Surveyor Guidelines and the aforementioned sample deficiencies, policies and procedures and resident care plans need to reflect an active and committed program for incontinent residents. Facilities must maintain data that demonstrates success in helping residents achieve or maintain bladder control.

### LIABILITY ISSUES

With the advent of the revised federal guidelines on urinary incontinence, a heightened awareness of the liability issues facing nursing facilities is important. Residents, families, and the legal community will look to the government for documented evidence of staff neglect. A new onset of urinary incontinence, loss of dignity, infection, sepsis, or skin breakdown may be linked to negligence in care. There are an increased number of law firms publishing information on their websites regarding incontinence and providing readers direction on how to pursue a case of facility neglect. The administrator should ask the following questions:

- Does the facility have a duty or obligation to perform a service, such as following a toileting schedule, for a particular individual?
- Was there a breach in this duty or obligation as outlined in the facility’s policies and procedures or did care fall below an applicable standard of practice?
- Was there injury or harm that occurred to the resident, such as loss of dignity, life threatening urinary tract infection, or skin breakdown?
- Is there a cause that links the facility’s breach in care directly to the injury or harm that occurred to the resident?

Residents and families often cite lack of assistance in toileting as the reason why a resident has lost control of their bowel or bladder function. This may prevent a resident from remaining independent and returning to the community. Education and communication with the resident and family on the types of incontinence, possible reversible causes, and treatment options must be discussed to foster an understanding of the issues involved. Although there is limited documentation on lawsuits initiated thus far because of urinary incontinence per se, the negative outcomes of incontinence, such as skin breakdown leading to decubitus ulcers, have been leading causes for lawsuits against facilities.

PERCENTAGE OF LOW-RISK RESIDENTS WHO LOSE CONTROL OF BOWEL OR BLADDER ON A STATE-SPECIFIC BASIS

35 – 39%		40 – 44%		45 – 49%		50 – 54%		55 – 59%		60 – 64%		65 – 69%	
MO	36%	OK	40%	CT	45%	AZ	50%	VT	55%	SC	60%	HI	60%
LA	38%	AR	42%	IN	45%	NY	50%	VA	55%	PA	61%	ME	69%
IL	39%	IA	41%	MS	46%	NC	52%	CA	56%				
		WY	42%	NM	47%	DC	53%	NV	56%				
		CO	43%	UT	47%	ID	53%	WA	56%				
		KS	43%	MN	48%	MD	54%	AK	57%				
		NE	43%	MT	48%			OR	57%				
		ND	43%	NH	48%			MA	58%				
		OH	43%	TN	48%								
		RI	43%	DE	49%								
		TX	43%	FL	49%								
		WI	43%	GA	49%								
		AL	44%	KY	49%								
		NJ	44%	MI	49%								
				SD	49%								
				WV	49%								

clinical business  
INCONTINENCE

## CLINICAL FACTORS

### IDENTIFYING TYPES OF URINARY INCONTINENCE

There are various types of urinary incontinence, which include:

- **STRESS INCONTINENCE**  
Loss of small volumes of urine with activities such as coughing, sneezing, running, laughing, and lifting.
- **URGE INCONTINENCE**  
The most common type of urinary incontinence among elderly persons, characterized by abrupt urgency, frequency, and nocturia (part of the overactive bladder diagnosis). The resident may feel the need to void but is not able to inhibit voiding long enough to toilet.
- **MIXED INCONTINENCE**  
Symptoms and/or signs of both stress and urge incontinence.
- **OVERFLOW INCONTINENCE**  
Occurs when the bladder is distended from urine retention. Symptoms include markedly reduced urinary stream, incomplete or unsuccessful voiding, dysuria, nocturia, frequency, incomplete voiding, bladder distention, and frequent or even continuous urinary dribbling.
- **FUNCTIONAL INCONTINENCE**  
Generally residents with functional incontinence have normally functioning urinary systems and the incontinence is the result of external factors such as physical or cognitive impairments, medications, or environmental impediments.
- **TRANSIENT INCONTINENCE**  
Temporary or occasional incontinence related to a potentially reversible cause. For example, urinary tract infection, increased urine production, or fecal impaction.

### IDENTIFYING CAUSES OF BOWEL INCONTINENCE

- Disease states such as diabetes, Parkinson's disease, CVA, and multiple sclerosis
- Spinal cord injury
- Medication
- Dementia

### ASSESSMENT OF INCONTINENCE

Assessment of the resident is the first step in identifying the type of incontinence, the resident's risk factors, and possible reversible causes. The clinician should perform a comprehensive assessment in a sensitive manner using a private area. Determining the type of incontinence is extremely important as it helps to identify appropriate interventions. Facilities should have policies and procedures that assure incontinence assessments are completed for all residents upon admission and whenever the resident experiences a change in mental status, physical ability, or urinary tract function.

### A THOROUGH ASSESSMENT INCLUDES:

- Prior history of incontinence
- Voiding/defecation patterns
- Fluid intake patterns
- Medication review
- Use of urinary tract irritants or stimulants
- Functional capabilities
- Cognitive capabilities
- Pertinent diagnoses
- Pelvic and rectal exams
- Environmental factors
- Types and frequency of assistance needed
- Post-void residual
- Assessment for bladder rehabilitation program
- Assessment for possible reversible causes

### INTERVENTIONS FOR INCONTINENCE

- Behavioral Programs
  - Bladder and bowel rehabilitation/bladder and bowel retraining
  - Pelvic floor muscle rehabilitation
  - Prompted voiding
  - Habit training/scheduled voiding
- Intermittent catheterization or chronic indwelling catheter
- Pharmacologic therapies
- Pelvic support devices (pessaries)
- Surgical therapies
- Absorbent products and garments
- Managing pain
- Treatment of underlying conditions

### COMPLICATIONS OF INCONTINENCE

- Alterations in skin, including pressure ulcers
- Urinary tract infection
- Impact on resident's quality of life
  - Loss of wellbeing and self-esteem
  - Isolation
  - Depression

One of many issues presented in MyZiva's course on "Urinary Incontinence and Use of Urinary Catheters" is how urinary incontinence contributes to a resident's loss of wellbeing and self-esteem. This is a traumatic experience for many residents. The importance of an accurate assessment that includes identification of the type of urinary incontinence presented is key in assuring appropriate interventions are instituted. This course includes a discussion on the types of urinary catheters along with measures to decrease the risk of urinary tract infections and to treat those that do occur. The integration of regulatory requirements and how they relate to urinary incontinence is also discussed, and emphasis is placed on the caregiver's recognition of the resident's individual needs and the ability to best serve those needs.

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For more information about these and other courses offered by MyZiva, please go to [www.MyZiva.com](http://www.MyZiva.com).

### FISCAL IMPLICATIONS

Incontinence care accounts for approximately eight percent of nursing home costs.

Our unofficial estimate is that the average nursing facility in the United States provides daily incontinent care to approximately 50 residents who require a minimum of five adult briefs per day. That boils down to an average facility use of 91,250 adult briefs each year. Costs are not exclusive to cloth or disposable briefs. The total cost of resources used to change incontinent residents, including labor, gloves, briefs, and laundry, is \$17.21 per resident/per day.<sup>3</sup>

The chart below summarizes the impact over time of incontinence brief use at an average facility:

ADULT BRIEF USAGE BY AVERAGE FACILITY	
DAILY	50 residents x 5 briefs = 250 briefs
WEEKLY	7 days x 50 residents x 5 briefs = 1,750 briefs
MONTHLY	30 days x 50 residents x 5 briefs = 7,500 briefs
ANNUAL	365 days x 50 residents x 5 briefs = 91,250 briefs

Multiplying 91,250 briefs by the number of licensed nursing homes in the United States – 16,011 facilities – we see that US Nursing Homes use 1,461,003,750 adult briefs each year.

Just to be clear, that is **ONE BILLION, FOUR HUNDRED SIXTY ONE MILLION, THREE THOUSAND, SEVEN HUNDRED FIFTY** adult briefs each year.

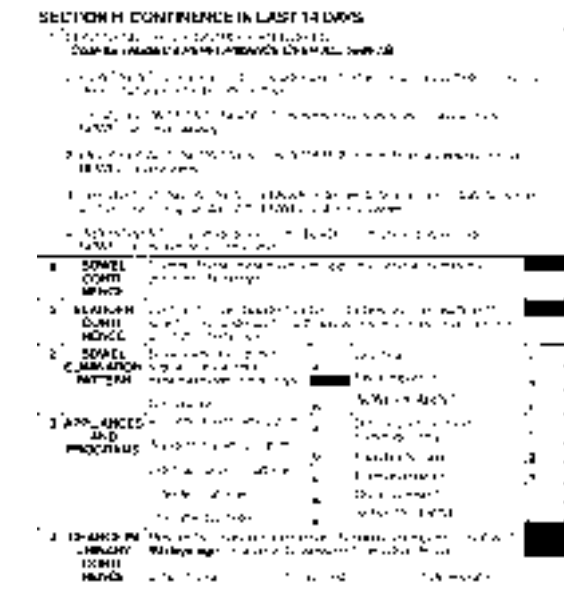
While these estimates are interesting from an industry-wide perspective, nursing home decision makers should analyze usage and the compounding cost incurred within their own organizations.

### WHAT STEPS CAN NURSING HOME DECISION MAKERS TAKE TO ENSURE FISCAL INTEGRITY?

First and foremost, ensure that your residents are properly assessed and cared for in regard to incontinence.

- Evaluate your direct and indirect incontinence costs over the past three years.
  - Direct costs include adult briefs, gloves, ointments/creams, cleansing solutions, disposable washcloths, and linens.
  - Indirect costs include an allocation of staff time, in-service training, other equipment, and supplies.
- Understand the connection between reimbursement and the care of incontinent residents as well as the applicability of relevant guidelines and regulations.
- Analyze MDS and other clinical data to ensure that quality care is being provided and undesirable resident outcomes, such as decubitus ulcers resulting from poor incontinent care, are being avoided. The following excerpt from the December 2002 Revised Long Term

Care Resident Assessment Instrument User's Manual for the Minimum Data Set (MDS) Version 2.0 should be familiar to all administrative, financial, and clinical staff:



Deficient care not only hurts residents, but costs facilities time and money. It is also likely to adversely impact your reputation, census, and survey performance.

Nursing home decision makers must understand and appreciate the correlation between incontinent care and staff time. For example, how much time does it take for a staff member to change the incontinence products of the residents assigned to their care? Are staff members properly trained? What is the cost of in-service training? Are the products and services used by the facility of acceptable quality and purchased at a fair and competitive price?

Given the money involved, the competitive nature of the incontinence industry, and its commitment to quality care, many of the leading manufacturers and distributors of incontinence-related products provide their clients with excellent training and software applications to assist with cost containment and quality control.

### TECHNOLOGY AND EMERGING TRENDS

As in many areas of nursing home management, technology can play a significant role in the management of urinary incontinence. Technological devices that have been used in home care situations and in rehabilitation facilities are finding their way into the nursing home environment as residents, families, and staff members become more "tech savvy." Individuals are sophisticated in researching resources to encourage independence and deal with the psychological and practical issues of urinary incontinence. Examples of devices available include:

- Biofeedback devices: portable devices that provide feedback to individuals performing pelvic floor muscle exercises.

- Bladder scanners: non-invasive ultrasound devices used to determine the volume of urine in the bladder. This information is used to assess for residual urine left in the bladder following voiding (post-void residual, or PVR). A series of scans is also used to establish function patterns useful in developing an individualized voiding schedule as part of a total incontinence training program.
- Enuresis alarms: devices that alert the resident or their caregiver when an incontinent episode has occurred. Types of alerts include audible sounds, flashing lights, or vibrating alerts.
- Functional magnetic stimulation: a non-invasive therapy whereby a magnetic field is applied to the perineum that induces nerve impulses. These impulses cause the contraction and relaxation of the pelvic floor muscles.
- Voiding reminders: devices used to enhance a bladder training or habit training program. These devices may come in the form of a watch, pager, or pocket device with an audible tone or vibration mechanism that is set to remind residents at specified intervals that it is time to void.
- New medications: pharmacological agents such as antimuscarinic agents for the treatment of an overactive bladder may decrease the number of incontinent episodes while increasing the volume of urine per episode. Transdermal skin patches, which deliver the medication slowly through the skin, have resulted in a significant reduction in anticholinergic side effects. Medications generally require a trial of one to two months to properly assess the effect. Monitoring of potential side effects and evaluation of adverse events are critical when initiating a new medication regime.

## CONCLUSION

Although incontinence is only one of many issues nursing homes have to contend with, it is one with significant cost implications. In addition to financial considerations, nursing homes are constantly put under a microscope by survey agencies, watchdog groups, residents, families, and the media. This is a challenge many other businesses do not face.

Assuring resident needs are met, risk management issues are addressed, and cost containment policies are adhered to is the responsibility of all key departments, who must work together to assure positive outcomes. Keeping costs down, providing top quality care, and preserving the dignity of our residents is of paramount importance.

For ease in addressing these issues, an **Administration Incontinence Checklist** is provided. The completion of this checklist by appropriate personnel will give the administrator a comprehensive view of the impact of incontinence on the fiscal, clinical, and compliance readiness of the facility. By using this or similar audit tools, administrators can benchmark key indicators to assure that resident rights are protected, the facility is “survey ready,” and fiscal resources are being used appropriately. The “Urinary Incontinence and Use of Urinary Catheters” course on MyZiva.com contains many tools to assist facilities in their efforts to deal with the myriad challenges associated with incontinence. These include:

- QA Audit Tools
- Urinary Incontinence Assessment Form
- Voiding Diary
- MyZiva Bladder Retraining Program

In addition, the MyZiva Bowel Retraining Program can be found on the “Constipation and Fecal Impaction” course.

A facility’s commitment to quality, fiscal integrity, and collegiality promotes positive outcomes within the organization while helping to strengthen the public perception and appreciation of nursing homes nationwide.

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<sup>1</sup> Centers for Medicare and Medicaid Services, Nursing Home Quality Initiatives.

<sup>2</sup> Michelle Bell, RN, BSN, and Melissa DeMarinis, MBA. “The Psychological Cost in Incontinence” (Extended Care Product News - ISSN: 0895-2906 - Volume 109 - Issue 4 - May 2006)

<sup>3</sup> Barton Frenchman. “Cost of Urinary Incontinence in Two Skilled Nursing Facilities: A Prospective Study.” *Clinical Geriatrics* 9 (January 2001), [www.skinandaging.com/cg/displayArticle.cfm?articleID=cgac203](http://www.skinandaging.com/cg/displayArticle.cfm?articleID=cgac203).