

Urinary Incontinence Case-Based Activity  
Long-Term Care Learning Activity

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Item	Description
Objective:	Given a scenario, the surveyor will identify areas of concern, potential citations, related regulatory requirements, and write the deficient practice statement.
Prior to Class:	Print copies of the scenario. Have the long-term care regulations available. Have flip charts and markers available. Provide copies of the Scope and Severity grid to each new surveyor.
Total Time for Activity:	60 minutes (The time given is approximate.)
Set-Up:	Set class up for small groups as needed.*

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Step:	Preceptor Instructions:	Activity Time:
1.	Divide the class into small groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario.	25 min.
4.	As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	
5.	Debrief the scenario by discussing key points.	25 min.

\*For individual assignment, provide direction and support where appropriate during the completion of the scenario. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.

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Directions: Read the four scenario and components (*Observations, Document Review, Physician Orders, and Interview*) and answer the questions at the end using the resources provided by your preceptor. When completed, turn in your answer sheet to your preceptor to discuss and review.

Resident Eight—Anna

*Observations*

Anna Wiggins (R8) was watching television in her room seated in her wheelchair on 06/12/2012 at 3:38 PM. Anna was wearing maroon-colored pants. The pants had a large wet area noted and her room had a strong urine odor. Anna stated that she was wet, and it was noted that urine was dripping down the seat of her wheelchair. At 4:15 PM, Ann was sitting on the toilet with her saturated pants on the floor. A large puddle of urine was on her bathroom floor with her incontinent pad hanging on the bathroom railing. At 4:30 PM, Anna's perineal skin was reddened. The Director of Nursing (DON) assisted Anna with peri-care. The DON stated that Anna gets these reddened areas because she won't ask the staff to toilet her. Anna's physician's diagnoses consisted of congestive heart failure and diabetes. In addition, Anna has chronic problems that included obesity, urinary frequency with occasional infection, hypertension, and gout.

Anna's quarterly Minimum Data Set (MDS), dated 04/12/12, identified that she was alert, oriented, and always incontinent of urine and needed extensive assist with transfers, toileting, and personal hygiene. Anna's care areas assessment worksheet indicated that Anna had the following modifiable factors contributing to transitory urinary incontinence: psychological or psychiatric problems; pain; restricted mobility; diseases and conditions—diabetes, congestive heart failure, depression; the type of incontinence listed as urge; that Anna received diuretics that can cause urge incontinence; and the care plan considerations with the objective to show improvement. The summation indicated that Anna was incontinent of urine, had a history of incontinence and urinary tract infections, had urge incontinence, was independent with toileting, wears an incontinent product, and is able to change it independently with assistance as needed.

Anna's plan of care, dated 04/30/2012, identified the following:

- Incontinence related to poor toileting habits as evidenced by saturated incontinence products
- Instructed staff
  - To provide incontinent products
  - Assist with peri-care as needed
  - Remind to toilet before and after meals, at bedtime, on rounds, and upon rising in the morning

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*Document Review*

During the document review, it was noted that Anna had an undated Kardex card being used by the nursing assistants. This card instructed staff to remind Anna to toilet before and after meals, at bedtime, and on rounds during the night and upon rising in the morning.

Anna did have a urinary continence evaluation in her chart dated 04/04/12. It identified Anna as having urge incontinence (inability to delay voiding). The document also identified Anna as having multiple daily episodes of urinary incontinence and that she is at risk for urinary tract infections. The evaluation further indicated that Anna used the bathroom almost every hour with multiple episodes of urinary incontinence throughout the day. It also indicated that Anna requires staff assistance with the use of incontinent products most of the time. The summation of the evaluation indicated that staff was to remind Anna to use the bathroom before and after meals.

*Physician's Orders*

Anna's physician's orders, dated 4/29/2012, are as follows:

Diet: Diabetic; no concentrated sweets and regular texture  
Advair discus (100/50 mcg) 1 puff bid  
Allopurinol 200 mg qd  
AM lodipine bysylate 2.5 mg qd  
Aspirin 81 mg qd  
Calmoseptine externally prn to perineal skin  
Furosemide 40 mg bid  
Levemir 40 units at HS  
Loper AMide 2 mg 2-caps after each loose stool up to three times per day  
Losartan potassium 50 mg qd  
Metformin 500 mg qd  
Nystatin powder topically to intertrigo prn  
Omeprazole 20 mg qd  
Oxygen, two liters per minute per nasal cannula prn

*Interviews*

When interviewed on 06/13/2012 at 7:00 AM, Anna stated that staff only offers to assist her to toilet at night and that they do not offer to toilet her during the day. Anna also stated that staff has not talked to her about the risks of sitting in saturated incontinent products.

The nursing assistant was interviewed on 06/13/2012 at 2:11 PM, and stated that Anna was not on a toileting AM program. The nursing assistant also stated that Anna was usually incontinent of urine three times a day on her shift.

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During an interview on 6/14/2012 at 9:00 AM, the Director of Nursing (DON) stated that Anna does refuse toileting and staff should remind Anna to use the toilet. The DON further stated that Anna does need assistance with her peri-care because she does not clean herself very well.

Survey Scenario Questions:

1. What areas of concern do you have? (Document on the flip chart provided.)
2. If you noticed any areas, would you stop the nurse and point these out? (Document on the flip chart provided.)
3. How would you continue to investigate your concerns? (Document on the flip chart provided.)
4. Do you think there will be deficiencies cited? Defend your answer. (Document on the flip chart provided.)
5. Based on the information given, what do you think the possible Severity would be for this case?
6. Write a deficient practice statement for this situation.

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Preceptor Answer Sheet

Directions: Preceptor, document your answers in the spaces below prior to completing this activity. Use this information during your debrief.

1. What areas of concern do you have? (Document on the flip chart provided.)
  - Resident sitting in urine soaked incontinence product
  - Resident is on toilet every hour and still having multiple incontinent episodes.
  - Resident not educated on skin risks related to incontinence
  - Toileting “reminders” do not consider timing of diuretics
  - Discrepancy between urinary continence assessment which indicates Anna usually needs assistance with incontinence care and care plan which instructs staff to “remind” resident and does not address this need
  - Discrepancy between DON who states that resident refuses toileting and resident who says toileting is not offered until the evening
  
2. If you noticed any areas, would you stop the nurse and point these out? (Document on the flip chart provided.)
  - No, there were no observations that required immediate surveyor intervention.
  
3. How would you continue to investigate your concerns? (Document on the flip chart provided.)
  - Review medical care- is diabetes controlled? Urinary infections?
  - Interview resident and/or family to see if they are included in care planning decisions and toileting plan
  - Interview direct care staff to determine if Anna refuses toileting
  
4. Do you think there will be deficiencies cited? Defend your answer. (Document on the flip chart provided.)
  - Yes, based on the information given the new surveyor should consider the following:
    - F241 Dignity, resident obviously wet with urine dripping
    - F279 Comprehensive Care Plan does not address her needs
    - F312 ADLs, as resident not receiving needed assistance
    - F315 Urinary Incontinence as there is no plan to address modifiable factors or institute any type of plan or trial to improve her incontinence

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5. Based on the information given, what do you think the possible severity would be for this case?
  - Based on the information given the new surveyor should identify the severity level as 2 with the potential for 3 based on findings of the further investigation
6. Optional: Write a deficient practice statement for this situation. If there are multiple tags, refer to your preceptor for guidance regarding which deficient practice statement to complete.

*To the Preceptor:* You may use this learning activity to help the new surveyor become more proficient with Principles of Documentation. To do this, be sure to give the new surveyor the information needed to complete a deficient practice statement.