

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

Item	Description
Objective:	Given a scenario, the surveyor will identify areas of concern, potential citations and 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.*

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.

Surveyor:

Date:

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Directions: Read the three scenario components (*Observations*, *Document Review*, and *Interviews*) 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 57—Rachael

Observations

On 07/11/2012 at 8:41 AM, two nursing assistants transported Rachael Ride (R 57) in her wheelchair to her room after the breakfast meal. The assistants helped Rachael with getting into bed, and one aide checked Rachael's incontinent product. It was dry, so it was not changed. The nursing assistants did not place Rachael on the toilet or ask Rachael if she wanted to use the toilet, even though Rachael was dry.

The second aide stated that the last time Rachael's incontinent product was changed was at 6:30 AM when she was assisted from the bed to wheelchair during morning care. The nursing aide added that the incontinent product was wet. The other nursing aide stated that Rachael was on a "check and change every two hours" program.

Rachael's diagnoses include:

- Alzheimer's disease
- Depression
- History of urinary tract infections
- Hypertension
- Dementia

Rachael's annual Minimum Data Set (MDS), dated 05/14/2012, identified that Rachael was severely cognitively impaired and required extensive assistance with toileting. The MDS also indicated that Rachael was always incontinent of urine. Rachael's care area assessment, completed on 05/12/2012, indicated that Rachael was always incontinent of bowel and bladder.

Rachael's care plan, dated 05/24/2012, directed two staff members to assist Rachael with her toileting, to change the incontinence product every two hours, and to take the resident to the bathroom every two hours.

The nursing assistant daily assignment sheet, dated 07/10/2012, indicated that Rachael was to be toileted every two hours with extensive assist of two staff members and to use a mechanical lift on the first transfer in the morning.

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Document Review

Rachael's "Bladder & Bowel Functional Assessment," dated 05/8/2012, indicated that Rachael needed the help of two nursing assistants to get to the bathroom. A note on this assessment also indicated that there were times when Rachael required the use of a mechanical lift. Medications include antidepressants, antianxiety and/or hypnotics, beta-blockers, laxatives and/or stool softeners, and antibiotics. The assessment identified the following risk factors: voids in large amounts, no apparent voiding pattern, wore briefs, and was always incontinent of bladder. The assessment did not identify the type of incontinence or the bladder program. The assessment summation identified that while Rachael was incontinent of bladder and wore a brief, she was often able to alert staff when she believes she needs to use the toilet. She is toileted every two hours and as needed. There was no mention of her leg pain and how that may or may not affect her ability to use the toilet.

Interviews

The following interviews were completed:

- On 07/11/2012 at 1:12 PM, the nursing assistant stated that Rachael's incontinent product was checked and changed every two hours. If Rachael is wet, she is not placed on the toilet to void. The nursing assistant further stated that she only puts Rachael on the commode in the tub room when she needs to have a bowel movement because she had "behaviors" associated with her left leg pain when she moves.
- On 07/12/2012 at 8:36 AM, another nursing assistant was interviewed and stated that Rachael was always incontinent of bladder and that they have been directed to check and change her incontinent product when they assisted her into bed. The nursing assistant also said that they do not take Rachael to use the toilet or commode unless she has asked to use it.
- On 07/12/2012 at 8:43 AM, during an interview, the Case Manager (CM-A) stated staff are instructed to toilet Rachael every two hours based on the three-day initial bladder assessment which was completed when she was admitted to the facility. CM-A stated that the facility replaces the initial three-day bladder assessment with the "Bladder and Bowel Functional Assessment" once it is completed; and since Rachael has no voiding pattern, she is on an every two hours toileting schedule. However, Rachael has had increased leg pain recently, so the staff has been directed to lay Rachael on her bed, because "we don't want her to sit or lie in wetness." CM-A reviewed Rachael's care plan and stated that it does direct the staff to take Rachael to the bathroom every two hours, but more often if the staff checks and changes the incontinent product and does not assist Rachael to the toilet.

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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. Optional: Write a deficient practice statement for this situation if directed by your preceptor. If there are multiple tags, refer to your preceptor for guidance regarding which deficient practice statement to complete.

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Preceptor Answer Sheet

Directions: Preceptor—The following lists the major points related to the scenario. Use this information during your debrief.

1. What areas of concern do you have? (Document on the flip chart provided.)
 - Left leg pain: assessment, cause, and treatment
 - There are no diagnoses associated with left leg pain
 - Care plan interventions not carried out—staff seem to have different interpretations of what should be done
 - Care plan not updated regarding ability to toilet and leg pain
 - Resident not toileted when incontinence product dry

2. If you noticed any areas, would you stop the nurse and point these out? (Document on the flip chart provided.)
 - No, there is no evidence that immediate surveyor intervention is required

3. How would you continue to investigate your concerns? (Document on the flip chart provided.)
 - Interview nurse who coordinates care planning regarding the assessments and the team's rationale for the care plan interventions. Also determine how staff is informed of care plan interventions.
 - Interview nursing staff and review medical record to determine onset, type, duration, and other pertinent findings regarding left leg pain.
 - Review latest MDS pain assessment.
 - Interview MD regarding left leg pain and related tests/interventions/medications.

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 surveyor may consider the following for deficiency citation if supported by the full investigation:
 - F 280 Comprehensive Care Plan Revision, due to leg pain
 - F 309 Quality of Care regarding leg pain
 - F 315 Urinary Incontinence

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5. Based on the information given, what do you think the possible Severity would be for this case?
 - As presented it appears to be a level 2, however, the new surveyor should be able to articulate that based on the investigation findings regarding the left leg pain, this might rise to a level 3.
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.