



## Restorative Nursing

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# Objectives

- Participants will be able to:
  - State the requirements for coding Restorative Nursing Programs on the MDS
  - Identify the components of a Restorative Nursing Program measurable goal
  - Identify the components of a Restorative Nursing Program comprehensive evaluation

What comes to mind when you think of a RNP?

# What is Restorative Nursing?

- Nursing interventions that promote the resident's ability to reach their highest level of function.
- The goal of a Restorative Nursing Program (RNP) is to restore as much independence as possible and/or prevent declines function.
- RNPs help the resident do for themselves rather than staff doing for the resident.

## **We do RNPs :**

- To improve the resident's quality of life by helping the resident improve and/or maintain their independence in ADLs and mobility
- To minimize the risk of a decline in ADL function

## **Why it is important to prevent declines???**

Declines in ADLs can lead to:

Depression

Withdrawal/Social isolation

Complications associated with immobility (i.e. incontinence and pressure ulcers.)

Deficiency's

Dependent resident's require more facility resources (staff time)

A RNP is more than just normal nursing or custodial care. Anytime you see the word Program on the MDS whether it be a RNP, a TP, T/R program it will require additional effort and documentation above and beyond usual nursing care.

## When is a RNP Appropriate?

- When a **restorative need** is identified
  - A newly admitted resident with no therapy orders
  - A long term resident showing signs of a decline
  - In conjunction with therapies
  - When therapy is discontinued
- Most residents in a SNF are candidates for a RNP that focuses on maintaining and expanding their self-involvement in ADLs.

**A resident has to have a restorative need to be on a restorative nursing program**

### **Examples of RNPs**

Teaching a resident with aphasia a new way to communicate

Providing supervision and verbal cues combined with allowing the resident enough time to complete an activity independently

A group exercise program for a resident without an identified restorative need would not be a RNP, it would be a wellness program/activity.

A restorative program must be individualized for each resident based on a assessment of their restorative needs.

There are no one size fits all or “cookie cutter” restorative programs. Each restorative program should be unique to the resident.

# Who Is Appropriate For A RNP?

Start with these basic questions:

- Can the resident do what they want and/or need to do independently?
- If not, why? What are the barriers that prevent the resident from doing so?
- What can be done to assist the resident to overcome the barriers?

The need for a RNP is determined by a comprehensive assessment of the resident

Residents who are coded as independent in an ADL activity are usually NOT candidates for a RNP. What is the need?

When trying to determine who is appropriate for a RNP a good place to look is at section G of the MDS

- Residents who are at risk for or have limitations in ROM
- Resident's who require assistance with ADLs are good candidates
- Residents who have balance problems, experience falls, swallowing or communication problems maybe good candidates

Other things to consider-

- What are the resident's goals for health and wellbeing. What are their preferences?
- Is the resident willing to participate in a RNP?
- What is the resident's ability to participate in and benefit from a RNP?

# Technique Programs

- Technique Programs Include:
  - PROM, AROM, Splint and Brace Assistance
- Staff is completing the activity with or for the resident.



There are two types of Restorative Nursing Programs

There are Technique Programs- these are programs that maintain flexibility and joint motion. In techniques programs staff is completing the activity with or for the resident

- PROM
- AROM
- Splint/Brace Assistance
  - Teaching the resident how to apply, manipulate, and care for a brace or splint or
  - A scheduled program where staff apply, remove, and care for the splint or brace.

Splint and brace assistance minutes include assessment of the resident's skin and circulation under the device, repositioning the limb in correct alignment, and cleansing the resident's skin and brace.

Splint and Brace Assistance programs do not include ROM before applying a splint. The ROM program would be captured separately, in AROM or PROM

Common errors:

- Combining minutes for AROM and PROM
- Coding AROM minutes in PROM or PROM minutes in AROM

## Training and Skill Practice Programs

- Training and Skill Practice programs improve the resident's ADL Self-Performance

*Bowel and Bladder Programs	Amputation/Prosthesis Care
Dressing/Grooming	Eating/Swallowing
Communication	*Ambulation
*Bed Mobility	Transfers

- The resident is performing the activity with cues, supervision or task segmentation from staff

The second type of Restorative Nursing Program is a Training and Skill Practice Program. Training and Skill Practice programs improve the resident's self performance in ADL activities.

Training and Skill Practice programs are intended to prevent functional declines in ADLs by improving or maintaining the resident's **SELF PERFORMANCE** in the ADLs.

**Training and Skill Practice programs include ANY intervention that improves or maintains the resident's self performance in the ADL.**

- A training and skill practice program for a resident who is unable to ambulate independently d/t repeated falls may include interventions to improve balance as well as ambulation.

Key to Training and Skill Practice programs, is **the resident is performing the activity with physical and/or verbal cues, supervision and/or task segmentation that is provided by staff.**

Often the focus of a RNP is on ambulation or ROM. RNP can be incorporated into the resident's care plan for any of these ADLs.

**How do RNPs impact reimbursement???** (two RNPs, 15 minutes each, for at least six of the seven days in the look back period).

- To count a day of RNP there must be 15 minutes of RNP in a 24 hour period.
- The 15 minutes do not have to be all at once, they can be added up over a 24 hour period.
- The minutes for each activity are coded separately. Activities cannot be combined to obtain the 15 minutes needed (e.g. 7 minutes AROM and 8 minutes PROM=15 minutes).
- Only the time staff spends with the resident is counted (e.g. the time the resident actually wears the splint is not included).
- The minutes must be documented.

\*These programs, when used together, will be counted as one program.

- Bed Mobility and Ambulation,
- PROM and AROM, and
- Bowel and Bladder Programs

## Coding Criteria

- **ALL** of the following criteria must be met to code a RNP on the MDS.
  - Measurable objectives and interventions must be care planned and documented in the medical record
  - Periodic evaluation by a RN
  - Nursing Assistants must be trained
  - Program supervision is provided by a nurse RN/LPN
  - Groups are limited to 4 residents per 1 staff

- There must be a periodic evaluation by an RN that identifies the resident's progress towards the goal. The evaluation must be completed at least quarterly (2 weeks before the ARD and prior to the completion of the assessment).
- Nursing Assistants/Restorative Aides must be trained, not only in how to complete the RNPs, but **also in techniques (tips and tricks) that promote the residents involvement in the activity.**
  - **Can therapy staff participate in a RNP? Yes, a therapist may participate in RNP however, nursing staff are responsible for the coordination and supervision of the program.**
  - A facility may elect to have licensed rehabilitation professionals perform restorative nursing activities. The therapist's time spent providing the maintenance service can be included when counting restorative nursing minutes.
- A nurse (LPN or RN) must supervise the activities in a nursing restorative program to ensure the program is implemented as written. What is included in supervision?
  - **Reviewing the documentation,**

- **Observation of the resident and care as it is being provided, and**
- **Interviews with both the staff and the resident.**
  
- Some facility's have large group restorative nursing activities with multiple staff members participating and supervising the activity. The 4:1 ratio must be maintained during these large group programs and **there must be a system in place with documentation to show the 4:1 ratio was maintained** during the activity.
  - When completing group exercise activities, you need to monitor the quality of the program for each resident.

**A lack of a measurable goal and a thorough evaluation are the two most frequent reasons for Case Mix Review adjustments during an audit.**

# Restorative Nursing Care Plans

A restorative nursing care plan has three components:

- A clearly defined problem statement that identifies the restorative need and resident's baseline
- **A measurable goal**
- Individualized interventions

A RNP must be care planned

A RNP care plan is developed after a thorough assessment of the resident's strengths, preferences and restorative needs.

# A Clearly Defined Problem Statement

- A clearly defined problem statement identifies the
  - Resident's restorative need (aka. the problem)
  - What is causing the problem
  - The effect the problem has on the resident

**Problem + Cause + Effect = Clearly Defined**

A restorative Care Plan begins with a clearly defined problem statement

- First, identify the restorative need.
  - What is the problem?
  - What is it that the resident cannot do?
  - What ADL activity are you trying to restore/preserve?
  - What do you want to prevent or maintain.
- Next, identify what is causing the problem.
  - Is it a medical diagnosis?
  - Why can't the resident do what they want or need to do?
- Finally, what is the effect of the problem on the resident?
  - How do you know it is a problem for the resident.
  - What is the resident showing you?
  - What is the resident's current or baseline level of function? Identify your starting point.

Problem + Cause + Effect = Clearly Defined Restorative Need

## Problem Statement Examples

- The resident is unable to ambulate independently related to Parkinson's disease as evidenced by an unsteady, shuffling gait, weakness and a history of falls.
- The resident is at risk for contractures in UE/LE ROM r/t CVA and R side hemiplegia as e/b the resident displays signs of hemi-neglect and does not initiate movement with the affected extremities.

We know that if a resident does not walk, sooner or later they will lose the ability to walk and eventually they may not be able to bear their own weight with transfers and may even develop contractures. The same can be true for a resident who does not move an extremity. They need to move it or they'll lose it.

Sometimes we see the RNP or Wellness program listed as the problem.

**A RNP is not the problem it is an intervention for a problem.**

Often we see "at risk for" problem statements when the resident clearly already has the problem. A resident either has the problem or they are at risk for it.

If a resident is at risk for a problem, do they already have the problem? If I say the resident is at risk for contractures? They do not have a contracture.

If the resident is at risk for a problem they don't yet have the problem. If a resident is at risk for a problem describe what they are at risk for and why they are at risk for it.

**It is a lot easier to develop a measurable goal for a problem if the restorative need has been clearly identified**

# Recommended Care Plan Format

## **The Problem Statement-**

- The resident is unable to \_\_\_\_\_ r/t \_\_\_\_\_ as e/b \_\_\_\_\_.
- The resident is at risk for \_\_\_\_\_ r/t \_\_\_\_\_ as e/b \_\_\_\_\_.

## **The Goal Statement-**

- The resident will \_\_\_\_\_.
- The resident will continue to \_\_\_\_\_.

The problem statement identifies what the resident cannot do and the goal statement identifies what you want the resident to do.

This format is only a recommendation, it is not a requirement

# Measurable Goals



A restorative nursing care plan must have a measurable goal.

SMART goals are measurable goals

CMS requires that **ALL** care plan goals be measurable not just the RNP goals

**The SMART Acronym identifies the five components of a measurable goal**

Measurable goals are Specific, Measurable, Attainable, Relevant, and Time Bound

## A SMART Goal is Specific

- It identifies exactly what the resident is expected to accomplish.
- The resident will:
  - Be able to raise both arms straight above their head
  - Put on their shoes independently
  - Eat breakfast independently
  - Be continent of bladder during waking hours
  - Fully extend their right leg so that the back of the knee lays flat on the bed

The resident will continue to get dressed daily with only verbal cues from staff

These are very specific statements

When writing goals try to keep it simple. More words is not better.

DO not include interventions-

The resident will ambulate 100 feet BID (**with assist of one and a walker**)

Do not tie ROM goals to function-

- 1) The resident will be able to raise her left arm high enough to comb the back of her hair.
- 2) PROM UE to maintain ability to feed self after set up
- 3) AROM LE to maintain ability to self propel wheelchair
  - It is possible for a resident to have a decline in ROM and still be able to comb the back of their hair, feed themselves, and self propel their wheelchair. It is better to identify the extent of the limitation/contracture if one is present. If no limitation in ROM is present say so

When goals are tied to function the evaluation tends to talk more about the ADL activity vs. the resident's ROM.

ROM problems need ROM goals. ADL problems need ADL goals. The evaluation has to address the resident's progress towards the goal. Not mixing your Technique Programs (ROM) with your Training and Skill Practice Programs (dressing and grooming) will minimize

this.

Do not say the resident will be able to raise her right arm high enough to comb the back of her hair.

- Say instead, the resident will be able to raise her left arm high enough to place her palm on the back of her head.

Where limitations in ROM exist you can measure the degree of the limitation 45° or 90°, but it is not necessary to do so. A word of caution if using a measurement system that calculates the degree of limitation, you want to make sure the person(s) doing the measuring have been trained appropriately and they are using a consistent approach to measure the limitation(s) to ensure they are accurate and to enable you catch signs of decline sooner rather than later.

# A SMART Goal Can Be Measured

A SMART goal identifies the criteria that will be used to measure the resident's progress towards the goal.



## Identify how will you determine if the resident has accomplished their goal?

- **The measurement must be precise to ensure all staff who evaluate the RNP will reach the same conclusion**
- What measurements will be used.
- There must be a monitoring system in place to document the resident's **participation and progress in the RNP.**

For a goal of, the resident will eat breakfast independently, the daily documentation will need to identify how much of breakfast was eaten independently and what interventions were utilized and how often during the meal.

If the goal is not measurable, it is not possible to determine if the resident is making progress toward the goal.

Measurable goals do NOT include interventions. The resident will participate in or tolerate a UE/LE AROM program 10 reps BID is not a goal. It is an intervention.

Participation in or tolerating a RNP is not the goal of the RNP. Participation in or tolerating a RNP is how the resident will reach their goal. The goal is what you are trying to accomplish with the program.

# A SMART Goal Is Attainable

- The goal must be realistic.
- The goal should be moderately challenging.
- The goal should be attainable in a short period of time.



Goals should not be so lofty that they are difficult to reach.

Start small and expand your goals as the resident makes progress. When the resident masters one component of an activity add another component. Break larger tasks up into smaller segments

A Dressing Example:

First, the shirt. When this is mastered add the pants....

Resident's with dementia learn best through repetition, a dressing RNP that is completed 3X/wk may not be beneficial.

## A SMART Goal is Relevant

The goal must be related to the problem



ROM Problems need ROM Goals, Dressing Problems need dressing goals

If a goal is not relevant to the problem is a lot like trying to fit a square peg into a round hole, it doesn't fit and it cannot be measured.

**Example: A goal of “the resident’s weight will remain between 135-145 pounds for the next 90 days” may be specific, measurable, attainable and time bound; however, it is not be relevant for an eating RNP. Why?**

This goal addresses weight loss, not the ADL function of eating. An Eating Training and Skill Practice program is one that improves or maintains the resident’s self-performance in eating. The goal must be related to the ADL activity of eating. This may be a good nutrition goal, but it is not a good goal for a RNP. The goal does not assist the resident to improve/maintain their self-performance in eating. This goal can be achieved by staff feeding the resident or with a feeding tube.

## A SMART Goal is Time Bound



A measurable goal identifies a target date, or a time frame, in which the resident is expected to reach the goal.

Generally speaking, goals should not be permanent. We can't set them and forget them.

The resident's progress towards the goal must be monitored and evaluated at least quarterly and with a SCSA to determine if the goal has been met and/or if the RNP needs to be revised.

**When a goal is revised or interventions are changed don't wait 92 days before evaluating to determine how the resident is doing.**

For example:

A resident is doing really well on their current ambulation program of 100 feet qd. So the goal is expanded to 200 feet daily. You wouldn't want to find out when you sat down to do the resident's next quarterly assessment that the resident was frequently refusing to walk because they considered the task too daunting.

Consider checking with the resident and/or staff weekly to ensure the resident continues to tolerate the program until you are confident that it is no longer a concern.

## Examples of Measurable Goals

- The resident will walk 100 feet daily
- The resident will feed self finger foods at breakfast
- The resident will open the fingers of her left hand far enough to hold a spoon (or tennis ball or some other object)
- The resident will fasten the buttons on their shirt independently
- The resident will be able to fully extend their legs so that their legs rest flat on the bed.

These goals can be measured. They are specific and objective.

If the goal is not measurable, the resident's progress towards the goal cannot be determined.

Starting with a clearly defined restorative need will enable you to determine a measurable goal much easier. It will also be easier to evaluate the RNP.

## Inappropriate Goals

- The resident will do 8 arm flexes BID
- The resident will ambulate with a walker and assist of two.
- The resident will be clean, dry, and odor-free
- The resident will maintain current strength, flexibility and useful motion
- The resident will participate in the RNP qd

### What is wrong with these goals????

The resident will do 8 arm flexes two times a day.

#### **What does this goal measure?**

It is an intervention not a goal. Interventions are not goals. They are a means to assist the resident to reach the goal. An appropriate goal would address what you are trying to achieve with the arm flexes.

The resident will ambulate with a walker and assist of two daily.

**Is the goal measurable? This too is an intervention. How far will the resident walk? With a walker and assist of two? How much assistance? Are two people providing weight bearing support or limited assistance...?**

The resident will be clean, dry, and odor-free.

**This goal does not improve or maintain the resident's self performance in continence or toileting. Staff can keep a resident clean, dry and odor free. A Toileting program goal should focus on the level of bowel and/or bowel control.**

For example: The resident will be continent of bladder during waking hours  
The resident will have at least two continent bowel movements per week

The resident will maintain current strength, flexibility and useful motion

**How do you measure “current” and “useful?”**

**Who decides what is useful motion?**

**What is the resident’s current strength and flexibility.**

**Where are they trying to maintain strength and flexibility UE/LE??? Too many questions are left unanswered!**

The resident will participate in the RNP qd.

**Again, participation in the RNP is not the goal. It is a means to reach the goal. The goal identifies what we expect to accomplish with the RNP.**

The better (the smarter) the goal is, the easier it will be to determine individualized interventions and evaluate whether or not the resident is progressing towards the goal.

# RN Evaluation

## The evaluation must identify:

- The resident's progress towards the goal
- Any barriers that interfere with the resident's progress
- Interventions attempted to assist the resident to overcome the barriers
- An assessment of frequent refusals to participate in the RNP
- The rationale for the decision to revise, continue or discontinue the RNP



The final component of a RNP is the evaluation. The MR must contain evidence of a periodic (at least quarterly and with changes in the resident's condition) evaluation by a registered nurse.

The evaluation is completed to assess the effectiveness of the RNP. Is the program accomplishing what was intended? Were the objectives met? If not, why? What were the barriers that prevented the resident from reaching their goals? The evaluation should describe the resident's progress towards the identified goal of the RNP. If a lack of progress is identified, the evaluation should describe the barriers to the resident's progress and identify how you will help the resident overcome those barriers.

Resident refusals must be assessed. Why is the resident refusing? Was the resident on board with the plan to begin with or did the goal conflict with the resident's preferences or health goals? Do other factors play a role: pain, are staff following the program, is staff approaching at an inconvenient time, do staff have time to implement the program etc.

The evaluation must identify the rationale for the decision to revise, continue, or discontinue the RNP.

- If the resident is consistently meeting their goals why do you want to continue the same

program? Are they functioning at their maximum potential? Will they decline if the program was discontinued?

- If the resident is not meeting their goal, would you want to continue the same program? Probably should not.

# Inappropriate Evaluation

## The Goal-

- The resident will ambulate 100 feet daily

## The Evaluation-

- Goals met continue program



The goal: The resident will ambulate 100 feet daily

**Is this goal measurable? Yes**

**Is the evaluation comprehensive? No**

**Goals met continue program is not an appropriate evaluation.** An evaluation is more than a simple statement like “goals met continue program.” The evaluation must explain the resident’s progress towards their goal and the rationale for the decision to continue, discontinue, or revise the goal.

## RN Evaluation

Goal: The resident will ambulate 100 feet daily

**The Evaluation:**

The resident demonstrated this ability daily for the past two weeks. Staff believe the resident has the potential to walk even further; however, the resident is afraid and won't attempt to walk further if staff aren't with her. Will revise program to increase the number of feet she is walked. Will meet with her weekly to talk to her about her fears and how much she is achieving.

This evaluation identifies the resident's progress towards the goal and why the program is being revised, continued or discontinued.

Evaluations do not have to be two pages long to be thorough. This one is five sentences. It is possible because the restorative need was clearly identified and the was goal measurable.

You don't want your problem statements or goals to be too wordy. More is not always better.

Wordy care plans tend to confuse the issues and complicate writing the evaluation.

## Considerations for Continuing a RNP

- The decision to continue or discontinue a RNP must be based on a thorough assessment and documented in the medical record
- Is the RNP effective?
- Has the goal been met?
- Has the resident's maximum potential been achieved?
- Is the resident likely to decline if the RNP is discontinued?
- Is the resident willing to participate in the program?

The decision to continue or discontinue a RNP is always based on a thorough assessment of the resident's needs. The rationale for either decision should be documented in the evaluation of the RNP.

**Is the RNP effective?** If not, reassess. Do not modify the goal to the resident's currently level of functioning. Modify the interventions to assist the resident to meet the goal.

**If the resident is consistently meeting their goal, is the resident functioning at their maximum potential?** Maybe, maybe not. Often the only way to determine if the resident is functioning at their maximum potential is to revise the restorative program goal and monitor the resident's progress.

If a resident is consistently meeting their goals and the RNP is not revised, the evaluation should identify a rationale to explain how staff determined the RNP should be continued even though the resident has met their goals.

There may times when you want to continue the program when a goal has been met to enable the resident to maintain his/her current level of function; If the RNP was discontinued is the resident likely to decline? Maybe, maybe not.

If there is a concern that discontinuing the restorative program will result in a decline in ADLs, the evaluation should describe how this was determined. What evidence is this concern based on? The rationale for this decision must be documented in the MR.

Sometimes the only way to determine if the RNP is necessary is to discontinue it. Remember resident's who are independent are generally not candidates for a RNP. Recommend close monitoring when discontinuing a restorative program to capture any signs of a decline early. If seeing signs of a decline restart the program, maintenance program.

**Is the resident willing to participate?** Frequent refusals of care must be assessed. There is an F-tag for a failure to assess refusals of care. Staff should determine the reason for the refusals, accommodate resident preferences when possible and develop alternative interventions to promote the resident's participation in the RNP.

Residents do have the right to refuse treatment. Risk/Benefit education must be provided. If the resident continues to refuse, discontinue the program and document the rationale in the MR.

**Does providing risk/benefit education to a resident once who refuses absolve the facility from any further interventions or attempts to get the resident on board?** No, you will want to revisit this periodically especially if the resident is developing some of the potential complications d/t a lack of participation.

## Toileting Programs Requirements

- Implementation of an individualized, resident-specific toileting program that is based on an assessment of the resident's unique voiding pattern;
- Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and
- The resident's response to the toileting program is monitored and periodically evaluated

### Toileting Programs are RNPs

A toileting program may decrease, or resolve, incontinence and the complications associated with it. Research has shown that 25-33% of residents will have a decrease or resolution of incontinence in response to a toileting program. An individualized, resident-centered toileting program that is based on a thorough assessment may decrease or prevent urinary incontinence and minimize or avoid the negative consequences associated with incontinence.

CMS data reveals that more than 50% of the nursing home population experiences some degree of urinary incontinence. In an older individual, urinary incontinence is often caused by combination of factors. Identifying and treating potentially irreversible causes of incontinence may decrease or resolve the incontinence.

### **To code a TP on the MDS:**

1. The TP must be individualized and based on a comprehensive assessment of the residents' needs and voiding patterns.
2. The TP must be care planned and communicated to staff. The medical record must

contain evidence that the toileting program was implemented on at least four days during the look back period.

3. The resident's response to the toileting program must be monitored. A TP must be evaluated at least quarterly and whenever there is a change in the resident's cognition, continence or ADLs.

## Bowel and Bladder Assessments

A comprehensive B/B assessment includes an evaluation of the:

- History of Incontinence
- Type of Incontinence
- Elimination Patterns
- Fluid Intake Patterns
- Pelvic/Rectal Examinations
- Functional Factors
- Cognitive Factors
- Environmental Factors
- Medications
- Diagnoses

An effective TP begins with a thorough assessment. A resident should be assessed upon admission and whenever there is a change in cognition, physical ability or level of bowel of bladder control.

A comprehensive assessment of incontinence includes:

- The history of the resident's incontinence. Interview the resident and/or family if appropriate and review the medical record to determine the prior history of the incontinence, including the **onset, duration and characteristics, precipitating factors, previous treatment and/or management, including the response to the interventions and the occurrence of persistent or recurrent UTI**; Interview the resident, if possible, to determine what their goals are for bowel and bladder control.
- The type of incontinence is a key component of the assessment and helps to identify the appropriate interventions to address incontinence. Understanding what precipitates the incontinent episodes is important. Tests or studies may be indicated to identify the type of incontinence (e.g. PVR, UC)
- A review elimination patterns such as frequency, volume, nighttime or daytime, quality of stream and, for those already experiencing incontinence, elimination patterns over

several days

- A review patterns of fluid intake such as amounts, time of day, alterations and the use of urinary tract stimulants or irritants, like caffeine
- A pelvic and rectal examination is necessary to identify physical features that may directly affect urinary incontinence, such as prolapsed uterus or bladder, prostate enlargement, significant constipation or fecal impaction, or a distended bladder.
- Does the resident have functional and cognitive abilities that could enhance continence and/or limitations that could adversely affect continence, such as dementia, impaired immobility, weakness, decreased vision, pain with movement; Does the resident need prompting or physical assistance to get to the toilet, if so what kind?
- Are there any potentially reversible causes of incontinence (e.g. constipation, UTI, medications, mobility impairments?)
- Are there any environmental factors impacting the resident's incontinence. Does the resident use any devices that may restrict or facilitate a resident's ability to access the toilet (bed rails or restraints, a raised or low toilet seats), Is there adequate lighting? Does the resident have a fear of falling?
- Medications- Is the resident taking any medications that could potentially increase the risk of incontinence (e.g. medications with **anticholinergic properties** (may cause urinary retention and possible overflow incontinence), **sedative/hypnotics** (may cause sedation leading to functional incontinence), **diuretics** (may cause urgency, frequency, overflow incontinence), **narcotics**, alpha-adrenergic agonists (may cause urinary retention in men) or antagonists (may cause stress incontinence in women) **calcium channel blockers** (may cause urinary retention)
- Diseases or Conditions- Determine if the resident has any diseases or conditions that may increase the risk of incontinence (e.g. BPH, Prostate Cancer, Diabetes, CHF, Depression, neurogenic bladder, MS)

Once the resident's incontinence has been thoroughly assessed and the type of incontinence determined, staff will have the information necessary to develop an individualized toileting program.

# Types of Toileting Programs

Two types of Toileting Programs.

- Programs that require the resident's cooperation and motivation in order for learning and practice to occur:
  - Bladder Rehabilitation/Bladder Retraining
  - Pelvic Floor Muscle Rehabilitation
- Programs that are dependent on staff involvement and assistance, as opposed to resident function:
  - Prompted Voiding
  - Habit Training/Scheduled Voiding

It is important that the resident possess the skills necessary to be successful with interventions being attempted.

- Consider whether the resident have the ability to comprehend and follow through on education and instructions?
- Can the resident identify bowel or bladder urges?
- Can they learn to inhibit or control the urge to void until reaching a toilet?
- Can they contract the pelvic floor muscle (Kegel exercises) to lessen urgency and/or urinary leakage?
- Do they respond to prompts to void?

There are two types of toileting programs

- Programs require the resident's cooperation and motivation in order to be successful
- Programs that are dependent on staff involvement and assistance in order to be successful

## **Bladder Rehabilitation/Bladder Retraining**

Behavioral Program that requires the resident to resist or inhibit the sensation of urgency, to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.

- Bladder Retraining Programs are appropriate for residents who:
  - Are cognitively intact and fairly independent with activities of daily living
  - Have occasional mixed or urge incontinence
  - Are aware of the need to urinate (void)
  - Have a goal to maintain his/her highest level of continence and decrease urine leakage.

### **Pelvic Floor Muscle Rehabilitation**

Kegel or pelvic floor muscle exercise to strengthen the pelvic floor muscles that contribute to closing the urethra and support of the pelvic organs.

- Pelvic Floor Muscle Rehabilitation programs are appropriate for residents who:
  - Are cognitively intact and are able to follow instructions
  - Have urge or stress incontinence
  - Are willing to implement interventions

The Toileting Programs that are dependent on staff involvement and assistance are:

### **Prompted Voiding**

A Prompted Voiding Program focuses on teaching the resident, who is incontinent, to recognize bladder fullness or the need to void, to ask for help, or to respond when prompted to toilet. A prompted voiding program has three components:

- Regular monitoring with encouragement to report continence status
- Prompting the resident to toilet on a scheduled basis and
- Praise and positive feedback when the resident is continent and attempts to toilet.

A Prompted Voiding program is appropriate for:

- Dependent, cognitively impaired residents
- Who have mixed or urge incontinence

### **Habit Training/Scheduled Voiding**

Scheduled toileting at regular intervals, on a planned basis, to match the resident's voiding habits.

Residents who cannot self-toilet may be candidates for habit training or scheduled voiding programs.

## Toileting Program Goals

- The goal of a Toileting Program is to decrease or eliminate incontinence
- The goal must be measurable.
- Examples:
  - The resident will be continent of bladder during waking hours
  - The resident will have less than two episodes of bladder incontinence per week
  - The resident will be continent of bowel

Toileting programs are restorative programs. The goal of a TP is to decrease incontinent episodes.

The goal of a TP must be measurable e.g.

- The resident will be continent of bladder during waking
- The resident will have less than two episodes of bowel incontinence per week
- The resident will be continent of bladder between 8 a.m. and 12 p.m. qd

If the TP goal is not measurable, one really cannot determine if the toileting program is effective.

# Toileting Program Evaluations

- Toileting Programs must be evaluated at least quarterly and whenever there is a change in cognition, physical ability, or level of Bowel and/or Bladder control
- The evaluations must:
  - Address the resident's progress towards the goal
  - Be documented in the medical record
  - Completed by an RN

The medical record should identify the resident's level of BB control prior to starting the toileting program. The care plan must identify a measurable goal and the evaluation must identify the resident's progress towards the goal.

Some things to consider when evaluating the toileting program. You want your evaluation to be specific. Your documentation is critical.

- Is the TP effective? Is the resident meeting their goal?
- If not, why? What are the barriers that are preventing the resident from reaching their goal.
- Why you chose the TP you did?
- What you were expecting to accomplish with the TP?
- Are you accomplishing what you set out to do?
- If not what you are going to do differently?

A number of factors may contribute to the decline or lack of improvement in bowel or bladder control:

- An inaccurate assessment -Collecting inaccurate elimination pattern data may contribute to inappropriate interventions
- Inconsistent implementation of the interventions
- A lack of resident, family or significant other input

The resident's response to the toileting program must be monitored. If a toileting program leads to a decrease or resolution of incontinence, the program should be maintained. CMS expects the resident's response to interventions to be "meaningful." CMS provides an example of what they consider "meaningful." one less incontinent void per day.

When an incontinent resident is consistently meeting their goals, you will want to consider if more improvement is possible. This is accomplished by reassessing the resident's elimination patterns, adjusting the interventions, and reevaluating the resident's response to the interventions.

If the incontinence has not decreased or resolved with a toileting program, consider whether there are other treatable causes of incontinence present. Does the resident have a UTI or constipation? The resident may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.

Residents who do not respond to a TP consider whether the assessment is accurate and whether interventions have been implemented consistently and as directed by the resident care plan. An inaccurate assessment and inconsistent implementation of the care plan will likely lead to poor resident outcomes.

Residents who have been accurately assessed and for whom other reversible causes are not found should receive supportive management (such as check and change and good skin care). If there is no pattern to the resident's incontinence and the resident is always incontinent, the resident is not a candidate for a TP.

# Reminders

- Current Manual and any Errata Documents can be downloaded from the following web site:



<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MS30RAIManual.html>

## Contact Information

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