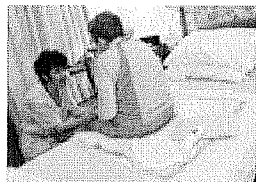




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Getting personal: Providers can expect greater demands from state surveyors once CMS's new guidance of incontinence care passes final clearance

James M. Berklan, April 18 2005



By its very nature, incontinence care is one of the most personalized endeavors in healthcare. Well, it's about to get even more personal.

New federal guidelines will mandate that state surveyors look to see that individualized incontinence care plans are made and followed for all nursing home residents. For months now, providers have been awaiting the new

Centers for Medicare & Medicaid Services guidance for F-tags 315 and 316 to be officially introduced.

Once it clears final review, a new era will have begun.

"Way, way tougher," is how Reta Underwood, the president of Consultants for Long-Term Care, Louisville, KY, describes it.

"They're going to force providers and caregivers to assess patterning for sure, and proper care when there is incontinence. Staff will have to be trained to provide good care techniques, and to ensure that only residents who are incontinent are treated that way."

That is one of the biggest criticisms today about incontinence care: Many residents are essentially expected to either be or become incontinent. It doesn't have to be that way.

Among other things, the new guidance will not allow providers simply to put residents in adult diapers automatically upon admission.

"It's putting the focus on continence management rather than incontinence care. If it does that, we will have a completely different mindset and orientation that we don't have now," Underwood said. "If it does just that one thing, we're in for a world of change, a tremendous shift in culture."

Underwood said she hopes CMS will draft the final guidance much the way it handled F-314, which addresses pressure ulcer care.

"It was heavily laden with the prospect of non-compliance because every step has to be proven it was completed," she said. "I expect CMS will draft this the same way. They're going to tighten it up."

Surveyor, doc views critical

The real challenge with the new guidelines will be how individual surveyors react to them, says Catherine DuBeau, associate professor in the section of geriatrics at the University of Chicago.

"It's unclear whether surveyors will look beyond documentation to care the care process," she said. "This is a huge concern in the field right now."

DuBeau also said staffing issues will once again come into the spotlight.

"Right now there's not really enough staffing for everyone who would benefit from toileting programs," she said. "So the DONs could be caught between administration and the surveyors."

Direct-care staff members are not the only ones who should be put on the spot, she added.

"The other group that needs to be at the table with this with incontinence care is physicians and nurse-practitioners," she said. "Now, all the accountability is on the staff side, which in some ways, isn't fair."

"There's more that can be done on the physician side," DuBeau said. "I won't make a lot of friends – I'm a nursing home practitioner, too – we certainly are not held accountable at all."

The American Medical Directors Association posts clinical guidelines at (www.amda.org), she noted.

The key to making any new guidelines work is caregiver involvement, says Judy Dutcher, chairwoman of the clinical practice committee for the Wound, Ostomy & Continence Nurses Society. She's skeptical about the new surveyor guidance.

"It's kind of like asking me what I thought of OBRA (the Omnibus Budget Reconciliation Act of 1987): I thought OBRA was great – theoretically," Dutcher said. "There can be a big bridge between what you put on paper and what is operationalized.

"I don't think we have moved forward much in terms of incontinence care in long-term care. The culture within long-term care is unique. Many front-line caregivers see incontinence care as an activity in futility."

Yet "up to 40%" of incontinent nursing home residents respond "very well" during the daytime to a toileting program, say nationally prominent researchers Drs. Joseph Ouslander and Theodore M. Johnson II, writing recently in the Journal of the American Medical Directors Association.

Thus, Dutcher notes, the need for caregiver "buy-in" has never been greater.

Another big problem is the "learned hopelessness" cycle that takes place in many facilities, she said.

"When I started in long-term care, a lot of times I heard a resident calling out that they have to go to the bathroom. The response would be one of two things: 'It's OK, you have a diaper on.' Or, 'We're making rounds in an hour.'"

"So, in other words it was, 'We're not on your schedule – you're on ours.' We'll be there, but if we're not? Oh, well. There's a lot of learned helplessness when nobody comes."

Government pushing change

Regulators appear bent on slowing that learning curve.

"No longer will it be acceptable for staff to just give residents briefs when they come into a facility. They will have to thoroughly evaluate their status and then pick an appropriate product for them," says Jeannette Podlogar, a Pittsburgh-based registered nurse and regional account manager for SCA/TENA. "There will be financial implications (punishment) if this doesn't happen. The government is going to force them to bring it to the forefront."

The result will be caregivers consulting a wider array of options, Podlogar believes.

"There are different styles of briefs and pads, and even toileting schedules that people do not put a lot of effort into," she said. "I think people in long-term care assume their options are relatively limited in terms of product selection."

In the past, some providers strictly used briefs to treat incontinent residents, explained Norma Finlayson, a clinical expert with Paper Pak, San Dimas, CA.

"But now they are looking for some assistance to use pads for light to moderate incontinence so people will have options," Finlayson said. "There is a large percentage of people in nursing homes fully incontinent and you do need to use a brief product, but there's also a large number of people being toileted and you want to teach to be independent. The proper diagnosis is the underlying factor there."

She thinks the new guidance will mean more work for providers. And, she agrees, surveyor interpretation will be pivotal. For example, where one might see a resident uncovered overnight as being properly "aired out," she said, another surveyor might object to it as a violation of dignity.

Keys to the future

Perhaps the biggest challenge for quality incontinence care remains high staff turnover. "Getting people educated is very, very difficult," notes Finlayson. Education is vital to getting consistent care processes in place, emphasizes Spencer Deane, vice president of marketing for SCA Personal Care's North America Division. Tracking costs and product usage is easier with a steady workforce, he said. He noted that many providers do not even attempt to adequately monitor their overall usage plans.

Looking ahead, Podlogar thinks disposable briefs have just about reached their limit with regard to absorbency. Instead, key changes may come in the way products are applied. TENA officials, for example, point to their Flex product, which they say can decrease caregiver back injuries because of the way it is strapped on. Underwood, the Kentucky-based consultant, has worked in another direction, helping bring a sensor-based product to market last November. The Twin Rivers/Stay Dri system is a wireless product that records when a patient starts to fill a brief, pages a caregiver and also notes when care is administered. The system also can do things such as recognize whether a bowel movement hasn't taken place for too long and transmit what size brief a resident will need replaced or if she is on a specific toileting program.

"It's impossible for a family member to say, 'I couldn't get to you in December, but Mom was wet and she's been wet for months now,'" Underwood said. "You can tell them she had an episode on Christmas Eve and was wet for only this many minutes, and actually show credibility because of data collecting. It empowers the facility."

The folks at Putnam County Care Center in Unionville, MO, are stepping off in a

similar direction. With the help of a state grant, the center is trying a CareTRAC sensor-based incontinence care system. A domino-sized sensor that picks up heat from a resident's brief will page a nurse if a resident starts to fill the brief.

"We can get to them quicker, get them changed quicker and avoid a skin breakdown," says Administrator Kathy Talbot. "Or maybe we can set up a pattern and then take the person before they need help. It sounds like a small thing, but even if we can get them once or twice a day, it can really make a resident's day."

Costs of incontinence

As a portion of medical/surgical costs portion of a typical nursing home budget:

Incontinence products 32%
Enteral feeding 19%
Gloves 12%
Wound care 6%
Woven/non-woven 6%
Meal/plastic/paper products 5%
Adhesives/bandages 5%
Point-of-care testing 5%
Skin care 4%
Respiratory 3%
Source: SCA, 2004

Keeping a closer watch

New federal incontinence care guidelines will specifically address:

Use of indwelling catheters without medical necessity
Poor catheter care
Repeated urinary tract infections
Lack of toileting program
No rehabilitation program
Poor hygiene – perineal care
Use of absorbent products
Source: Diane K. Newman, co-director, Penn Center for Continence and Pelvic Health, 2004