



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

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GOVERNOR

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MEMORANDUM

DATE: April 6, 2005

TO: Long Term Care Facilities

FROM: MDCH/Clinical Advisory Panel
Quality Improvement Nurse Consultants

RE: Clinical Process Guideline: Urinary Incontinence

Best clinical practice is only worthwhile to the extent that we use it to guide care for our residents.

Collaboratively, we are striving to improve urinary continence of nursing home residents in Michigan. The purpose of the Guide is to clarify how to apply the **Urinary Incontinence Process Indicator Checklist**. Electronic copies are available for reprint at www.michigan.gov/qinc.

This optional “best practice” tool was presented to you at the Spring 2005 Joint Provider/Surveyor Training on April 6, 2005. Effective date for usage of the tool is May 9, 2005. Both facilities and surveyors will have the opportunity to use the Checklist when urinary incontinence is of concern. Facilities will be accorded the opportunity to demonstrate that they have followed the steps in this guideline, as evidence to support an appropriate care process related to urinary incontinence.

A workgroup including doctors, nurses, educational specialists, and restorative care directors with experience in geriatrics and nursing home care discussed the topic in depth. They used generally accepted, current references in preparing these documents. The Process Indicator Checklist contains a series of steps related to urinary incontinence.

Best clinical practice information helps each facility provide the best possible care throughout the year. Along with information in the Federal OBRA regulations, our surveyors will use these Process Guidelines to review how your facility is managing urinary incontinence. We encourage you to examine your process regarding urinary incontinence to consider the application of the following information.

The Basic Care Process

The management of all conditions and problems in a nursing home should follow these basic steps:

Assessment/recognition: The purpose of this step is to provide a rational basis for deciding whether there is a need, risk, or problem and what to do about it. The facility's staff and practitioners collect relevant information about the resident (history, signs and symptoms, known medical conditions, personal habits and patterns, etc.) and then a) evaluate and organize that information to identify whether the individual has a specific need, condition, or problem; and b) describe and define the nature (onset, duration, frequency, etc.) of the risk, condition, or problem.

Diagnosis/cause identification: The facility's staff and practitioners attempt to identify causes of a condition or problem, or explain why causes cannot or should not be identified.

Treatment/management: The facility's staff and practitioners use the above information to decide how to manage a resident's condition, symptom, or situation. Where causes may be identifiable and correctable, they seek and address them or explain why they could not or should not have done so.

Monitoring: The facility's staff and practitioners evaluate the individual's progress over time in relation to a risk, need, problem, condition, or symptom, consider the effectiveness of interventions, and make a systematic determination about what to do next.