F315 AND THE RAI/MDS PROCESS

Has the revision of CMS F315 in June 2005 changed how we manage the RAI (Resident Assessment Instrument) and the MDS (Minimum Data Set) process? Although nothing has changed within the RAI or MDS coding, CMS F315 does address the need to include more supporting documentation within the medical record for the observation period and to create more individualized care plans for our residents requiring incontinence care.

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INCONTINENCE ASSESSMENT

Section "H" of the MDS assesses the resident for a 14-day look-back period, targeting continence and, if the resident is incontinent, the frequency of the episodes. Make sure that the incontinence assessment tools you use to meet the guidelines in F315 fall within the various MDS assessment time frames: new admissions, quarterly, annual, or with significant changes in medical status. Also, your bowel and bladder records, such as voiding diaries, should be done during this period so that the results can be used to make decisions within the RAP (Resident Assessment Protocol).

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTI-NENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTI-NENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with [illegible] programs, if employed	
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days Constipation	

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
		Bladder retraining program	b.	Pads/briefs used	g.
		External (condom) catheter	c.	Enemas/irrigation	h.
		Indwelling catheter	d.	Ostomy present	i.
		Intermittent catheter	e.	*NONE OF ABOVE*	j.
4.	CHANGE IN URINARY CONTI-NENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated			

RAI, MDS and RAP: A LAYMAN'S GUIDE

The RAI (Resident Assessment Instrument) is the overall process of assessment required by the government for long-term care facilities certified to participate in Medicare or Medicaid.

The MDS (Minimum Data Set) is a component of the RAI, a standardized set of over 600 screening items used for every resident. It is required to be submitted electronically to CMS on a regular basis (on admission, quarterly, or after significant change of status/ diagnosis).

The RAP (Resident Assessment Protocol): The MDS may uncover areas that need additional assessment, testing, and problem-solving. There are 16 areas the MDS will trigger for this supplementary assessment, one of which is incontinence. The RAP is a structured set of guidelines for assessing the resident's condition in more detail, leading to comprehensive documentation in the medical record and development of a complete and individualized care plan.

THE INCONTINENCE RAP

If the MDS triggers a concern such as incontinence, a further assessment using the Incontinence RAP is required. The following questions are used to prompt for further investigation and guide decision-making.

The Assessment Section of CMS F315 instructs the facility to complete the RAP, considering the following:

- Resident's history of incontinence
- Voiding pattern
- Medication review
- Fluid intake patterns
- Bladder stimulants
- Physical exam, including pelvic and rectal
- Cognitive abilities and physical weaknesses
- Assistance necessary
- Illnesses that contribute to bladder issues
- Tests such as postvoid residual and labs
- Environmental factors

RAP INCONTINENCE QUESTIONS FOR FURTHER INVESTIGATION

Questions	Does Guideline Apply?	Guideline Question
1	Yes/No	Is Incontinence related to other medical conditions? i.e. Delirium (B5), Fecal impactions (H2d), Depression (i1ee), UTI (i2j), Edema (J1g)
2	Yes/No	Is Incontinence related to the physical environment? i.e. Locomotion ability (G1c,d,e,f), Lack of access to toilet, Physical barriers, Restraints (P4)
3	Yes/No	Is Incontinence related to a medical diagnosis? i.e. Diabetes (I1a), CHF (I1f), CVA (I1t), Parkinson's (I1y)
4	Yes/No	Is Incontinence related to medications? i.e. Diuretics, (O4e), Parkinson's medication, Disopyramide, Antispasmodics, Antihistamines, Drugs that stimulate or block sympathetic nervous system, Calcium channel blockers (verapamil, nifedipine, diltiazem), Narcotics (medical record)
5	Yes/No	Is Incontinence related to psychoactive medications? i.e. Antipsychotics (O4a), Antianxiety (O4b), Antidepressants (O4c), Hypnotics (O4d)
6	Yes/No	Do these potential contributing factors exist? Pain (j2), Excessive or inadequate urine output, Atrophic vaginitis, Cancer of bladder, Cancer of prostate, Cancer of brain, Cancer of spine, Cancer of tabes dorsalis (medical record)
7	Yes/No	Are abnormal lab values present? i.e. High blood calcium, High blood glucose, Low B12, High BUN, High Creatinine (P9, medical record)
8	Yes/No	Have these tests been completed? Postvoid residual, Bladder stress for females, reflux test (kidney ultrasound for males with PVR> 100 mL. Tests are not indicated when resident is Comatose (B1) or No memory recall (B3a) AND Dependent in transfer or locomotion (G1b, c, d, e, f).
9	Yes/No	If indwelling catheter (H3d), has a voiding trial test been completed? Test is not indicated if Untreatable urethral blockage (I3), terminal illness (J5c) or stage 3/4 pressure ulcer (M2a) is present.

If you look at the RAP comprehensive assessment questions listed in the table above, many of them parallel this list of considerations from F315. The RAP questions have not changed, and yet many clinicians are not familiar with all of them. For example, the eighth box above asks whether a bladder stress test for females has been performed, but many nurses do not know how to carry one out. This is an item that was listed in the incontinence RAP long before the changes to F315. What F315 does is to guide surveyors to evaluate this process more closely.

F315 GUIDELINES AND CARE PLANNING

The decision-making of the RAP, which can be documented in many different ways within the medical record, leads to the formulation of your care plan for that resident. F315 has truly affected the care plan and the need for more careful documentation in that plan.

CMS has directed facilities with the revised F315 guidelines, using the following key words: **"It is important that the facility follow the care process (accurate assessment, care planning, consistent implementation and monitoring of the care plan with evaluation of the effectiveness of the interventions, and revision, as appropriate."**

Care plan meetings are an important part of the care process, according to CMS.

In the past, the documentation of "toilet before meals" or "toilet before bedtime" was common. CMS F315 makes it clear that more specific and individualized parameters need to be documented. The following examples come right from F315: "Toilet within an hour prior to each meal and within 30 minutes after meals, or check for episodes of incontinence within 30 minutes after each meal or specific times based upon the assessment of voiding patterns."

HOW WILL F315 BE SURVEYED?

As noted in *Investigation Protocol for Surveyors,* the surveyors are instructed to **"Determine if the facility assessment is consistent with or corroborated by documentation within the record and comprehensively reflects the status of the resident."** This means surveyors will be reviewing that your documentation is consistent in the assessment, the day-to-day charting, the care plan, and of course the current condition of the resident. Care plans will be reviewed to see if there are quantifiable objectives, time frames, and **"interventions specific enough to guide the provision of services and treatments."** Remember, too, that if a care plan refers to a particular facility protocol, your staff needs to be familiar with it and have easy access to it.

Your facility can be compliant with the intention of CMS F315 if you truly work through the RAI process, including the RAP guidelines; incorporate that decision-making into the care plan; and ensure that your staff is educated regarding incontinence causes and treatments and follows through consistently with that plan.

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