F315 Documentation Guidance and Implementation Strategies

Presented by

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Documentation Guidelines

F315 Regulation states:

- **A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and**
- **A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder functioning as possible.**

Documentation Guidelines

- **INTENT of F315**
  - **Each resident who is incontinent is identified, assessed and provided treatment and services to achieve or maintain as much normal urinary function as possible;**
  - **An indwelling catheter is not used unless there is valid medical justification;**
  - **An indwelling catheter is discontinued if it is not medically justified;**
  - **Services are provided to restore or improve normal bladder function after removal; and**
  - **A resident receives appropriate care to prevent infections**

Documentation Guidelines

- Should do a comprehensive assessment of bowel and bladder status, including a 3-day dairy:
  - Upon Admission
  - Re-admission if there is a change
  - Removal of a catheter
  - If there is a change in the continence status
  - The overall plan should be reviewed quarterly and annually

Documentation Guidelines

- A Comprehensive Bowel & Bladder Assessment should consider:
  - Prior history
  - Voiding patterns
  - Medication review
  - Patterns of fluid intake
  - Urinary tract stimulants or irritants
  - Pelvic and rectal examination
  - Functional and cognitive capabilities
  - Type of physical assistance necessary

Documentation Guidelines

- A Comprehensive Bowel & Bladder Assessment should consider:
  - Pertinent diagnoses
  - Identification of possible complications such as skin irritation or breakdown
  - Tests or studies to identify the types of incontinence
  - Environmental factors and assistive devices

Documentation Guidelines

- 3 Day diary
  - Time
  - How the resident voided
    - Incontinent
    - On toilet
    - Bedpan/commode, etc
  - If the resident was unable to use the toilet and/or refused
  - Dry or wet and amount of urine
  - If the resident requested the toileting
  - Bowel pattern
  - Area for comments or further description

Documentation Guidelines

- MDS – Section H
  - 14 day look back
  - Any scheduled Toileting plan:
    - Staff members at scheduled times each day either take the resident to the toilet room, give the resident a urinal, or remind to go to the toilet
  - Bladder Retraining Program
    - The resident is taught to consciously delay urinating. Encourage to void on a schedule rather than according to their urge to void.

Documentation Guidelines

- Care Plan
  - Developed from the Comprehensive Assessment, 3-Day Dairy and MDS/RAPS
  - Type/causes of incontinence
  - Goal
  - Specific bowel and bladder intervention/plan
    - Schedule
    - Products and Devices
    - Skin protection
    - Environment
- Plan must be communicated to the nursing assistants

Implementation Strategies

- Break your Bowel & Bladder programs down into two areas:
  - ♦Admission process
  - ♦On-going maintenance of a bowel and bladder program
- Utilize the Quality Improvement process when assessing each program
  - ♦ Start with small goals
  - ♦Target one unit to test the program

Implementation Strategies

- Prioritize which areas within each program is in most need:
  - Ensuring residents are actually being toileted per plan of care
  - Communication systems
  - Educational needs
  - Assessment & Documentation

Implementation Strategies

- Develop an Interdisciplinary Team
  - ♦May be the same team for pressure ulcers
    - Nursing (licensed and nursing assistants)
    - Dietary
    - Therapies
    - Physicians/Nurse Practitioners

Implementation Strategies

- Need to include:
  - ♦ The resident and family members
  - ♦ Even consider Housekeeping, Activities, Maintenance, etc.
    - Assist with answering call lights
    - Monitor equipment
    - Notify appropriate staff if a resident:
      - smells of urine or feces or incontinence visible
      - has not been given hydration

Implementation Strategies

- Nursing Assistants to drive the Bowel and Bladder Program
  - ✓ Solicit feedback and ideas
  - ✓ Empowerment
  - ✓ Consistent assignments and universal workers
  - ✓ Educate them on the types, causes and interventions of incontinence

Implementation Strategies

- ✓ Do you have effective communication systems:
  - ♦ Between shifts and between nursing assistants (last time toileted & turned at a minimum)
  - ♦ Are interventions being communicated to the nursing assistant (toileting schedule, absorbent products, devices to utilize, etc.)
  - ♦ During the 3-Day B & B Assessment

Implementation Strategies

Assessing the Admission Process

Admission Program

- Admission Process Assessment
  - Any pre-admission information you can gather from the resident and/or family, the better
  - Assess when your admissions happen – what staff are involved?
  - How is the 3-day diary & comprehensive assessment being initiated & is it getting done?

Implementation Strategies

- 3 Day Bowel and Bladder Dairy
  - Ensure ALL staff are aware the resident is being monitored (Therapy, Activities, Dietary, etc.)
  - Recommend the form have room for comments for each shift
  - Nursing Assistants MUST meet with the nurse at the end of the shift to discuss the results from the shift

Implementation Strategies

- Comprehensive Assessment:
  - Gather input from:
    - Resident
    - Family
    - Interdisciplinary Team

Implementation Strategies

- Comprehensive Assessment
  - Is the assessment tool comprehensive and assists the staff with determining the cause and type of both bowel and bladder habits/incontinence?
  - Does it encourage staff to develop an INDIVIDUALIZED and specific toileting plan?
  - May want to have some suggested interventions for staff to assist them

Implementation Strategies

- Catheters
  - Audit residents with catheters
  - Are they medically justified?
  - Are they addressed at each care conference?
  - Is there a process/policy in place for when a catheter is removed?

Implementation Strategies

- UTI's
  - Are you following the appropriate indications to treat a UTI?
    - Without catheter, should have at least 3 of the following:
      - Fever
      - New or increased burning pain on urination, frequency or urgency
      - New flank or suprapubic pain or tenderness
      - Change in character of urine

Implementation Strategies

- UTI's
  - With a catheter, should have at least 2 of the following:
    - Fever or chills;
    - New flank pain or suprapubic pain or tenderness
    - Change in character of urine
    - Worsening of mental or functional status. Local findings such as obstruction, leakage, or mucosal trauma may also be present

Implementation Strategies

- Recurrent symptomatic UTI's
  - Are you trending this?
  - Re-evaluate hygiene practice
  - Involves the Interdisciplinary Team?
  - Are preventative interventions communicated to staff?
  - Are preventative measures being implemented (hydration, cranberry juice, topical hormones, etc.)?

Implementation Strategies

- On-going Program
  - Do staff know when & what to report with bowel & bladder continence changes?
  - Does the IDT review all residents for a change in continence status (mobility, appetite, pain, cognition and elimination)?

Implementation Strategies

- On-going Program
  - Do you have a Hydration Program?
    - Never leave the room without offering fluids
    - Fluids given with medication pass
    - During activities
    - In Therapy
    - Mealtimes (do not overload at meals)
    - Preferences given (juices, fruits, vegetables, etc.)

Implementation Strategies

- On-going Program
  - Do you have a Bowel Maintenance Program?
    - Tracking for All residents that needs to be filled out after each shift
    - Targeted interventions if the resident has not had a BM in 2 and 3 days

Implementation Strategies

- Do you have monitoring programs in place
  - ✓Toileting schedules being followed
  - ✓Appropriate absorbent products being utilized
  - ✓Doubling up of incontinence products
  - ✓Catheter care and insertion
  - ✓Peri-care
  - ✓PVR
  - ✓Infection control trending of UTI's and re-occurrence of UTI's

Implementation Strategies

- ✓ Do you have appropriate equipment/supplies?
  - Barrier ointments and creams available at all times
  - Peri-care products/supplies
  - Proper fitting and the appropriate type of absorbent product
  - Bladder scanner
  - Raised toilet seats, commodes, bed pans, urinals, grip bars, lighting, etc.

Implementation Strategies

- Monitor documentation systems
  - Monitor that the B & B assessment and 3 day dairy are being done at appropriate intervals & accurately
  - Monitor that the plan of care reflects interventions being implemented
  - Monitor that the interventions/schedule is being communicated to the nursing assistants
  - Monitor that the documentation is consistent (physician orders, MDS/RAPS, care plan and nursing assistant assignment sheets)

Implementation Strategies

Documentation of refusal of cares should include:

- Discuss resident's condition
- Treatment options
- Expected outcomes
- Consequences of refusing treatment (macerated/denuded skin, pressure ulcer development, constipation, UTI and urosepsis)
- Offer relevant alternatives

Implementation Strategies

- Document the date of discussion in care plan and put resident's request in care plan
- Review quarterly, with re-admission and with change of condition

Implementation Strategies

- Do education on orientation and periodically throughout the year
- Include ALL staff as appropriate
- Give Nursing Assistants training on the causes, types and interventions for incontinence (not just the nurses)

Thanks for your participation!!!

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Types, Symptoms, and Management of Urinary Incontinence

	Type	Definition	Symptoms	Treatment Options	Dietary Approaches	Adjunct Therapy
Acute or Transient U.I.	**Transient**	Temporary episodes of UI that are reversible once the underlying cause(s) is/are identified and treated	Sudden onset of involuntary loss of urine from dribbling to large amounts	Behavioral: use of toileting devices Pharmacologic: review meds/ dosaging / interactions /Side effects Medical: treat underlying condition i.e., delirium	Drink 6 8oz glasses of water Reduce caffeine and intake of diuretic fluids: coffee, tea, colas	• Bedside commode • Urinal/bedpan • Skin care • Absorbent products
	Urge (Overactive bladder)	Associated with detrusor muscle over activity (excessive contractions of the smooth muscle in the wall of the urinary bladder resulting in a sudden, strong urge (also known as urgency) to expel moderate to large amounts of urine before the bladder is full	Abrupt urgency, frequency and nocturia. Can feel the need to void but unable to inhibit voiding long enough to reach and sit on commode.	Behavioral: Bladder training Pelvic muscle exercises Biofeedback Electrical stimulation (P.T.) Pharmacologic: Review timing of diuretics, consider anticholinergics or antispasmodics	Drink 6 8oz glasses of water Eliminate caffeine and intake of diuretic fluids (coffee, tea, colas)	• Bedside commode • Urinal/bedpan • Skin care • Absorbent products
Chronic U.I.	**Stress**	Associated with impaired urethral closure (malfunction of the urethral sphincter) which allows small amts of urine leakage when intra-abdominal pressure on bladder is increased.	Small amt of urine loss during physical exertion, coughing, laughing, sneezing, standing from a sitting position, lifting, climbing stairs	Behavioral: Pelvic muscle exercises Biofeedback/Sommatic innervation Pharmacologic: Alpha-adrenergics, Estrogen Surgical: Retropubic suspension Sling operation Needle suspension Collagen injections	Drink 6 8oz glasses of water	• Pessary • Weight loss • Skin care • Absorbent products
	Overflow	Leakage of small amounts of urine when the bladder had reached its maximum capacity and had become distended. Can occur from outlet obstruction from BPH, prostate ca, or urethral stricture. May also be caused by hypotonic bladder (outlet obstruction or impaired/absent contractility or neurogenic bladder	Weak stream, hesitancy, or intermittency, dysuria, nocturia, frequency, incomplete voiding **PVR- 5-10 min after void = 200ml (Dx-Overflow U.I.)** ***If 150-200- retest*	Behavioral: Prompted voiding Double voiding Crede' maneuvers Surgical: Relieve obstruction	Drink 6 8oz glasses of water	• Clean intermittent catheterization • Indwelling foley catheter • Skin care • Absorbent products

For more information contact Pathway Health Services at 1-877-777-5463 ♦ e-mail: consult@pathwayhealth.com

Types, Symptoms, and Management of Urinary Incontinence

	Type	Definition	Symptoms	Treatment Options	Dietary Approaches	Adjunct Therapy
Chronic U.I.	**Mixed**	Combination of urge incontinence and stress incontinence. Many elderly people (esp. women) will experience symptoms of both stress and urge.	Small amounts of urine with physical exertion, laughing, sneezing etc.. along with abrupt urgency.	Behavioral: Pelvic muscle exercises Biofeedback Pharmacologic: Alpha-adrenergics, Estrogen Review timing of diuretics, consider anticholinergics or antispasmodics. Surgical: Retropubic suspension Sling operation Needle suspension Collagen injections	Drink 6 8oz glasses of water	• Urinal / bedpan • Bed side commode • Environmental modifications • External collection devices • Skin care; absorbent products
	Functional	Incontinence that is secondary to factors other than inherently abnormal urinary tract function. May be related to physical weakness or poor mobility or dexterity*(i.e. d/t visual deficits, arthritis, stroke, contractures)* cognitive deficits *(i.e. confusion, dementia, unwillingness to toilet)* Medications *(i.e diuretics)* or environmental impediments *(i.e. excessive distance, poor lighting, low chairs, restraints, and toilets difficult to access)*	U.I. when there is impairment of physical or cognitive functions.	Behavioral: Scheduled toileting Bladder retraining Physical therapy Pharmacologic: Lower dosages or change medications	Drink 6 8oz glasses of water Consult dietitian Eliminate caffeine	• Bedside commode • Urinal / bedpan • Environmental modifications • External collection devices • Skin care • Absorbent products

F315 Urinary Tract Infections: ***Do not Treat Asymptomatic UTI***
Indications to treat a UTI without a catheter should have 3 of the following:

- ❑ Fever > 2 ° F or single measurement of oral temperature >100 ° F
- ❑ New or increased burning, pain on urination, frequency or urgency
- ❑ New flank pain or tenderness
- ❑ Change in character of urine(new bloody urine, foul smell or amount of sediment), lab report (new pyuria or hematuria), positive leukocyte estrase and nitrates –recommended use dipstick urine test as applicable)
- ❑ Worsening of mental or functional status (Confusion, lethargy, recent onset incontinence, decreased activity or appetite

#1 Goal is Prevention! Assess, good handwashing & pericare, increase fluids.
Asymptomatic bacteruria should NOT be treated

F315 Urinary Tract Infections: ***Do not Treat Asymptomatic UTI***
Indications to treat a UTI with a catheter, must have 2 of the following:

- ❑ Fever or chills
- ❑ New flank pain or suprapubic pain /tenderness
- ❑ Change in character of urine
- ❑ Worsening of mental status or function

Local findings such as obstruction, leakage or hematuria may also be present.
NOTE: Catheters will always have bacteria, change catheter prior to obtaining culture. *Do not use catheters unless medically justified.*
Asymptomatic bacteruria should NOT be treated

★ RESIDENT ASSESSMENT MUST HAVE AN INTERDISCIPLINARY APPROACH

For more information contact Pathway Health Services at 1-877-777-5463 ♦ e-mail: consult@pathwayhealth.com

Bowel and Bladder Assessment

Date:_____ ☐ Initial ☐ Annual ☐ Significant change ☐ New onset incontinence ☐ Catheter removal

Catheter: ☐ Not used Indications for use: Stage 3/4 pressure area, end stage disease process (i.e,- pain with changes), Urinary retention which cannot be treated medically or surgically
☐ Catheter reason/dx and type:_____ Size:_____ D/C Plan_____
☐ Discontinuation attempted date:_____ MD order ☐Yes Catheter change frequency_____
Has a MD or Urologist ever been consulted? ☐Yes ☐ No If so, when:_____. If straight cathed-frequency:_____
Has intermittent catheterization been attempted? ☐Yes ☐ No Comments:_____

Cognitive Awareness

Does the resident display any of the following: ☐ Short term memory loss ☐ Long term memory loss
Can the resident identify the need or urge to void/defecate? ☐ Yes ☐ No ☐ Some of the time
Able to use the call light? ☐Yes ☐ No ☐ Sometime Able to ask to go to the toilet? ☐ Yes ☐ No ☐ Sometimes

Elimination History (Include resident and family/representative)

Bladder: When did incontinence start? _____ ☐Unknown Duration:_____
☐ Wakes at night to void How many times?_____ Other significant patterns/characteristics:_____
☐ Has problems "leaking" urine Precipitating factors:_____
Any incontinent episodes with: ☐ Laughing ☐ Coughing ☐ Changing positions ☐ Sneezing ☐ Exercising

Bowel: Normal bowel pattern: Time of day ____ Times/ day or week ____ Incontinent of BM: Frequency_____
☐ Bowel movement pattern irregular ☐ Problems with loose stool or diarrhea Hx of hemorrhoids ☐ Yes ☐ No
Problem with constipation ☐ Yes ☐ No If yes, Bowel program: _____
Bowel Sounds: ☐ Present in all 4 quadrants ☐ Present x_____ quad. ☐ Diminished ☐ Hyperactive ☐ Absent

Symptoms Affecting Elimination Patterns

☐ Voids often and in small amounts	☐ Unable to void	☐ Urgency ☐ Dysuria
☐ Difficulty stopping stream	☐ Difficult starting stream	☐ Bladder spasms ☐ Mood/Behavior
☐ Dribbles while coughing/standing up	☐ Burning pain	☐ Hematuria
☐ Dribbles after voiding	☐ Distended bladder	☐ Polyuria
☐ Dribbles constantly	☐ Fever	☐ Urinary retention (inability to empty bladder)
☐ Unable to feel urge sensation	☐ Functionally disabled	☐ Psychological impact from incontinence
☐ Quality of stream- weak		☐ **None**

Diagnosis and Medications Affecting Elimination Patterns

Does the resident have any of the following diagnosis? *(Check all that apply)* ☐ CVA ☐ CHF ☐ Delirium
☐ Urinary disorders ☐ Edema ☐ Diabetes ☐ Atrophic Urethritis/Vaginitis ☐ Kidney/renal disease ☐ UTI's ☐ M.S.
☐ Dehydration ☐ Prostate problems ☐ Depression ☐ Parkinson's ☐ Recent surgery ☐ Bowel obstruction
☐ Dementia/Alzheimer's ☐ Pelvic organ prolapse ☐ Cancer ☐ Obesity ☐ Mental illness ☐ Behaviors ☐

Taking one or more of the following medications influencing *Lower Urinary Tract Functioning*?

☐ **N/A** ☐ Diuretics (urgency, frequency) ☐ Hypnotic/Sedative (sedation leading to UI) ☐ Antipsychotics (sedation-UI) ☐ Calcium Channel Blockers (*Verapamil, Cardizem, Nifedipine)* (Urinary retention) ☐ Anticholinergics (Parkinson's Meds, UI meds, antihistimines – retention, fecal impaction) ☐ Ace Inhibitors *(captopril, lisinopril)* (Cough-leading to stress incont.) ☐ Narcotics (Muscle relaxation, sedation leading to functional UI) ☐ Caffeine/stimulants (Urgency, frequency) ☐ Antispasmodics (muscle relaxation-leading to UI) ☐ Tricyclic Antidepressants *(Amitriptylline etc.)* (Retention) ☐ Beta Blockers (*Metoprolol etc.)* (urinary retention) ☐ History of antibiotic use

Mobility /Environmental Limitations Which Could Affect Elimination

☐ **N/A** ☐ Requires assist with ambulation ☐ Requires assist to transfer ☐ Fear of falling ☐ Requires mechanical lift
☐ Confined to chair ☐ Bed rest ☐ BR is not easily accessible ☐ Lighting ☐ Use of physical devices
☐ Uses adaptive equipment *(Hi/low toilet seat, bars, commode etc..)* List:_____

Pain *(Refer to Pain Assessment)*

Is pain or discomfort affecting elimination patterns ☐Yes ☐ No Comments:_____

Labs (Abnormal values in past 30 days or abnormal baselines)

☐ Elevated BUN:_____ ☐ Low B12 ☐ High creatinine:_____ ☐ Elevated blood glucose ☐ High blood calcium
☐ TSH ☐ Elevated WBC ☐ **None Noted**

Possible Reversible Causes for the Incontinence

☐ History of UTI (s) Usual symptoms (if any) _____ Last UTI_____

Resident Name:_____ MR#_____ Room_____

Toileting –Resident Self Performance (How resident uses the toilet/commode/bedpan and transfers on/off toilet, cleanses, changes pad. , adjust clothes)

❑ Independent ❑ Supervision, encouragement or cueing ❑ Requires non-weight bearing assist, resident highly involved
❑ Requires weight bearing assist, resident somewhat involved ❑ Resident requires total assist

Elimination Patterns

Urinary Patterns from 3-day void:

Resident shows **patterns of urinary continence** ❑ **Less than 2 hours** *or* ❑ **Greater than 2 hrs**

Comments on urinary patterns:_____

- Resident has patterns reflecting dribbling of urine ❑ Yes ❑ No
- Resident is able to use the toilet majority of time ❑ Yes ❑ No
- No Elimination Patterns ❑
- Resident has voluntary leakage of urine (behavior-refuses toileting) ❑ AM ❑ PM ❑ NOC

Bowel Patterns from 3-day void:

Patterns reflected for time of day ❑ Yes ❑ No **If Yes, Time of usual BM:** _____

Problem with constipation during elimination observation? ❑ Yes ❑ No

Suspected Type(s) of Incontinence *(Choose one)* ❑ **Urge** (sudden urgency) ❑ **Stress** (leaks with cough/ sneeze)

❑ **Mixed** (combination of both urge and stress)

❑ **Overflow (Same as Retention)** -leakage of small amt of urine when bladder is full -frequent dribbling, bladder fullness

❑ **Functional** (decreased mental awareness/decreased or loss of mobility or personal unwillingness)

❑ **Transient** (temporary episodes of urinary incontinence that are reversible once casual factors are treated)

Skin Integrity- Visual Inspection of Perineum, Genitalia and Rectum

Does resident have current skin breakdown in perineal area? ❑ Yes ❑ No Hx of skin breakdown: ❑ Yes ❑ No

Inspection of perineum, rectum, genitalia displays: ❑ Odor Discharge ❑ Prolapse ❑ Lesions ❑ Structural ❑ N/A

Patterns of Fluid Intake

❑ WNL Describe alterations in fluid intake:_____

Treatment Plan *(Select one primary plan)*

Elimination Plan	*Involve resident/representative in condition and treatment options and outcomes or refusal of treatment. Add plan to resident care plan.*		
❑ **Scheduled/Habit toileting plan** ***(Scheduled toileting at regular intervals on a planned basis to match voiding habits)*** • Cognitively Impaired • Functionally disabled • Caregiver dependent	❑ **Check and change program** ***(Designed for residents who are physically unable to sit on toilet or have cognitive impairment or behaviors that make it difficult to use)*** • Cognitive impairment • Functionally disabled	❑ **Training to return to previous pattern/retraining** ***(Behavioral technique that requires to resist or inhibit the sensation of urgency)*** • Oriented • Able to feel sensation • Able to understand and learn to inhibit the urge • Toilet Ind. or with minimal assist	❑ **Prompted voiding** *(Focus on teaching resident* • Able to use toilet - Feel sensation • Able say their name Or • Reliably point to one of two objects

Products:

❑ Brief ❑ Pull-up❑ Pads ❑ Snap pants with liner ❑ Panty liner ❑ Night time brief ❑ Other : _____

Size: ❑ Small ❑ Medium ❑ Large ❑ X-Large ❑ Adaptive clothing

Incontinent Devices:

❑ External collection system type:_____ ❑ Pessary ❑ Other: _____

Post Void Residual: **(5 minutes after void- repeat if >180cc)** _____

Analysis and Summary of Assessment Data

Signature (s):_____

_____

Resident Name: _____ MR#_____ Room_____

Bowel and Bladder Quarterly Review

Date:__________ ☐ Quarterly ☐ Significant Change

Bowel and Bladder Assessment Reviewed; Changes in assessment or 3- day void (if applicable)? ☐ Yes ☐ No

Interventions /Environmental Modifications Implemented:________________________________

Bowel Management Program Effective? ☐ Yes ☐ No **Toileting Program Effective?** ☐ Yes ☐ No
Evidenced by: ☐ Goal effective ☐ No skin breakdown ☐ Able to maintain some continence ☐ Other ____________

Changes or Revisions to Current Plan: ________________________________

Signature(s):________________________________

Date:__________ ☐ Quarterly ☐ Significant Change

Bowel and Bladder Assessment Reviewed; Changes in assessment or 3- day void (if applicable)? ☐ Yes ☐ No

Interventions /Environmental Modifications Implemented:________________________________

Bowel Management Program Effective? ☐ Yes ☐ No **Toileting Program Effective?** ☐ Yes ☐ No
Evidenced by: ☐ Goal effective ☐ No skin breakdown ☐ Able to maintain some continence ☐ Other ____________

Changes or Revisions to Current Plan: ________________________________

Signature(s):________________________________

Date:__________ ☐ Quarterly ☐ Significant Change

Bowel and Bladder Assessment Reviewed; Changes in assessment or 3- day void (if applicable)? ☐ Yes ☐ No

Interventions /Environmental Modifications Implemented:________________________________

Bowel Management Program Effective? ☐ Yes ☐ No **Toileting Program Effective?** ☐ Yes ☐ No
Evidenced by: ☐ Goal effective ☐ No skin breakdown ☐ Able to maintain some continence ☐ Other ____________

Changes or Revisions to Current Plan: ________________________________

Signature(s):________________________________

Date:__________ ☐ Quarterly ☐ Significant Change

Bowel and Bladder Assessment Reviewed; Changes in assessment or 3- day void (if applicable)? ☐ Yes ☐ No

Interventions /Environmental Modifications Implemented:________________________________

Bowel Management Program Effective? ☐ Yes ☐ No **Toileting Program Effective?** ☐ Yes ☐ No
Evidenced by: ☐ Goal effective ☐ No skin breakdown ☐ Able to maintain some continence ☐ Other ____________

Changes or Revisions to Current Plan: ________________________________

Signature(s):________________________________

Resident Name:________________________ **MR#**____________ **Room#**__________