This Inspection Guide provides ***guidance*** to the inspector during the initial planning of an inspection. Not all sections will be applicable in every situation and the inspector may need to adjust the inspection based on information collected.

PROFILE FOR RESIDENT

- Name, room number, home area
- Date of birth, date of admission, date of discharge (if applicable)
- Diagnoses
- Other resident information, as applicable: Physician, SDM, Advanced Directives, Activities of Daily Living, and RAI-MDS Outcome Scores, e.g., CPS

CLINICAL RECORD REVIEW (ELECTRONIC AND HARD COPY)

ASSESSMENTS

- RAI-MDS - Section H (Continence in Last 14 Days: Bowel & Bladder)
- Nutrition/RD assessments
- Continence assessments
- Other assessments as applicable, e.g., skin
- Documentation of care, e.g., flow sheets, tasks
- Voiding/bowel Diary or records
- Brief sizing assessment
- External consultations

PLAN OF CARE

- Plan of care is based on assessments
- Focus and goals for care are identified
- Strategies and interventions are in place to manage the condition, e.g., toileting routine)
- Specialized treatments
- Designated continence product

- Evidence of revisions when condition changes

MEDICATION ADMINISTRATION RECORD (MAR)

- Regular and PRN medications prescribed to manage the condition
- Recent medication changes, that medication is administered as prescribed, and the effectiveness of PRNs
- Bowel Management Protocol
- Medications prescribed that may have adverse side effects, e.g., constipation

TREATMENT ADMINISTRATION RECORD (TAR)

- Continence related treatments, e.g., catheter care
- Bowel related treatments, e.g., suppositories, enema
- Dietary Interventions

PROGRESS NOTES

- Notes specific to the concern being inspected.
- Documented bladder or bowel issues, e.g., UTI's, constipation.
- Medical conditions that may impact continence.
- Food and fluid intake.
- Strategies and interventions used and the effectiveness of these interventions, e.g., dietary interventions.
- The assessment and/or re-assessment of interventions, as needed.
- Notes from external consultations.

OBSERVATIONS

RESIDENTS

- Observe for signs of incontinence.
- Residents asking to be toileted/changed.
- Determine if toileting schedules are being followed.

- Correct continence product in use.

STAFF

- Staff to resident interactions with dignity and respect
- Staff's response to the resident's request to be toileted/changed
- Implementation of the plan of care
- Staff provide the correct level of assistance
- Residents being toileted regularly, e.g., before/after meals

OTHER CARE AND SERVICES

- Dietary interventions are provided as ordered.
- Determine if there is an adequate supply of incontinence products.

INTERVIEWS

RESIDENT/SDM

- Engage resident in conversation about their needs related to continence care and bowel management.
- Determine if the resident feels they receive the support they require to manage their needs and supplies are appropriate/adequate.
- Determine if interventions are effective, e.g., dietary, medications, continence product).

DIRECT CARE STAFF

PSW and others as applicable

- Discuss how staff are made aware of a resident's care needs, related to continence care and bowel management, e.g., plan of care, shift reports.
- Discuss what education and training the staff has been provided on continence care and bowel management, e.g., best practices, policies, product selection, supports available.
- Confirm their familiarity of the resident and their care.

- Confirm if the staff member is aware of the resident's needs related to continence care and the current interventions, e.g., toileting routine, level of assistance, product selection.
- Discuss the effectiveness of these interventions.
- Confirm what actions staff take if the interventions are ineffective, e.g., report to registered staff or RD.
- Determine if there are adequate incontinence supplies in the home.

REGISTERED STAFF AND MEDICAL PERSONNEL

- Discuss the approaches and tools used in the assessment and re-assessment of the resident's continence care and bowel management needs.
- Explore how staff monitor and respond to the effectiveness of interventions in place.
- Discuss the ways in which other members of the care team are involved in the response and management of continence care and bowel management, e.g., RD, physician, NP, Pharmacist, or specialized resources.
- Follow up on any concerns noted from record review, observations, and other staff interviews.

MANAGEMENT

Director of Care, Administrator/Delegate

- Confirm that the home has an incontinence team and discuss its function.
- Discuss the process for assessing/re-assessing and monitoring residents' continence care needs, and ordering incontinence products.
- Where needed, discuss the home's policy and procedures available for the continence care and bowel management program.
- Follow up on any legislative concerns noted from record review, observations, and other staff interviews.

OTHER RECORD REVIEW

- Communication tools, e.g., shift reports, physician book
- Video or other visual or audio recordings

- May review records of products ordered and received to establish sufficient supplies are available
- Policies and program relevant to continence care and bowel management
- Training records

FOR FURTHER GUIDANCE

Please refer to policies, guidance documents, and job aids available in the eInspectors' Handbook (for example: Food, Fluid Guide).