SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on urinary and bowel continence.

H0350: Bladder Continence

H0350. Bladder Continence (3-day assessment period.)	
Enter Code ☐	**Bladder continence -** Select the one category that best describes the patient. 0. **Always continent** (no documented incontinence) 1. **Stress incontinence only** 2. **Incontinent less than daily** (e.g., once or twice during the 3-day assessment period) 3. **Incontinent daily** (at least once a day) 4. **Always incontinent** 5. **No urine output** (e.g., renal failure) 9. **Not applicable** (e.g., indwelling catheter)

Item Rationale

- Bladder incontinence can:
  - — interfere with participation in activities;
  - — be socially embarrassing and lead to increased feelings of dependency and social isolation;
  - — increase risk of longer length of stay;
  - — increase risk of skin rashes and breakdown, and development and/or worsening of pressure ulcers;
  - — increase risk of repeated urinary tract infections; and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.
- For many patients, bladder incontinence can be resolved or minimized by:
  - — identifying and treating underlying potentially reversible conditions, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with new or recent onset of incontinence);
  - — eliminating environmental barriers to accessing commodes, bedpans, and urinals; and
  - — prompted voiding, or scheduled toileting and other interventions.
- For all patients, including those whose bladder incontinence does not have a reversible cause and who do not respond to interventions, the direct care staff should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.

2. Interview the patient if he or she is capable of reliably reporting his or her bladder continence. Speak with family members or significant others if the patient is not able to report on bladder continence.
3. Ask direct care staff who routinely work with the patient about incontinence episodes.

Coding Instructions

Complete only if A0250 = 01 Admission or A0250 = 10 Planned Discharge.

- Code 0, Always continent, if throughout the 3-day assessment period the patient has been continent of urine, without any episodes of incontinence.
- Code 1, Stress incontinence only, if during the 3-day assessment period the patient has episodes of incontinence only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.
- Code 2, Incontinent less than daily, if during the 3-day assessment period the patient was incontinent of urine once or twice.
- Code 3, Incontinent daily, if during the 3-day assessment period the patient was incontinent of urine at least once a day.
- Code 4, Always incontinent, if during the 3-day assessment period the patient had no continent voids.
- Code 5, No urine output, if during the 3-day assessment period, the patient had no urine output (e.g., renal failure, on chronic dialysis with no urine output) for the entire 3 days.
- Code 9, Not applicable, if during the 3-day assessment period the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire 3 days.

Coding Tips and Special Populations

- If intermittent catheterization is used to drain the bladder, code incontinence level based on continence between catheterizations.

Examples

1. Mrs. M is an 86-year-old patient and has had longstanding stress incontinence for many years. When she has an upper respiratory infection and is coughing, she involuntarily leaks urine. However during the current 3-day assessment period, the patient has been free of respiratory symptoms and has not had an episode of incontinence.

   Coding: H0350 would be coded 0, Always continent.
   Rationale: Even though the patient has history of intermittent stress incontinence, she was continent during the current 3-day assessment period.

2. Mr. A has multi-infarct dementia. He was incontinent of urine twice on day 1 of the 3-day assessment period, once on day 2, and once on day 3.

   Coding: H0350 would be coded 3, Incontinent daily.
   Rationale: The patient had at least one episode of urinary incontinence every day over the 3-day assessment period.

3. Mr. O has Parkinson's disease, has very limited mobility, and cannot be transferred to a toilet without risk of injury. He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed. He does not have a continent void during the 3-day assessment period.

   Coding: H0350 would be coded 4, Always incontinent.
   Rationale: The patient was incontinent of urine during the 3-day assessment period, and cannot be toileted due to very limited mobility. Incontinence is managed by a scheduled check and change protocol (intermittent check on patient to determine if perianal hygiene and changing of undergarment is necessary).

4. Mrs. T had one urinary incontinence episode during the 3-day assessment period. All other voids were continent because the Certified Nursing Assistant (CNA) followed a timed toileting schedule to assist Mr. T to the toilet.

   Coding: H0350 would be coded 2, Incontinent less than daily.
   Rationale: The patient had one incontinent episode during the 3-day assessment period.

5. Mrs. W had an indwelling catheter that remained in place during the entire 3-day assessment period. There were no episodes of urinary incontinence.

   Coding: H0350 would be coded 9, Not applicable.
   Rationale: The patient was not incontinent because she had an indwelling catheter.

6. Ms. R was diagnosed with chronic renal failure and had no urinary output during the 3-day assessment period.

   Coding: H0350 would be coded 5, No urine output.
   Rationale: The patient had no urinary output during the 3-day assessment period due to chronic renal failure.

H0400: Bowel Continence

H0400. Bowel Continence (3-day assessment period)	
Enter Code ☐	**Bowel continence -** Select the one category that best describes the patient. 0. **Always continent** 1. **Occasionally incontinent** (one episode of bowel incontinence) 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. **Always incontinent** (no episodes of continent bowel movements) 9. **Not rated,** patient had an ostomy or did not have a bowel movement for the entire 3 days

Item Rationale

- Bowel incontinence can:
  - — interfere with participation in activities;
  - — be socially embarrassing and lead to increased feelings of dependency and social isolation;
  - — increase risk of longer length of stay;
  - — increase risk of skin rashes and breakdown, and development and/or worsening of pressure ulcers; and

- increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted due to urgency.

- For many patients, bowel incontinence can be resolved or minimized by:
  - identifying and managing underlying and potentially reversible conditions, including medication side effects, constipation and fecal impaction, and immobility (especially among those with a new or recent onset of incontinence); and
  - eliminating environmental barriers to accessing commodes, bedpans, and urinals.
- For all patients, including those whose bowel incontinence does not have a reversible cause and who do not respond to interventions, the direct care staff should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel incontinence flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the patient if he or she is capable of reliably reporting his or her bowel habits. Speak with family members or significant others if the patient is unable to report on continence.
3. Ask direct care staff who routinely work with the patient about incontinence episodes.

Coding Instructions

Complete only if A0250 = 01 Admission.

- Code 0, Always continent, if during the 3-day assessment period the patient has been continent for all bowel movements, without any episodes of incontinence.
- Code 1, Occasionally incontinent, if during the 3-day assessment period the patient was incontinent for bowel movement once. This includes incontinence of any amount of stool at any time.
- Code 2, Frequently incontinent, if during the 3-day assessment period the patient was incontinent for bowel movement at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.
- Code 3, Always incontinent, if during the 3-day assessment period the patient was incontinent for all bowel movements (i.e., had no continent bowel movements).
- Code 9, Not rated, if during the 3-day assessment period the patient had an ostomy or other device, or the patient did not have a bowel movement during the entire 3 days. Note that patients who have not had a bowel movement for 3 days should be evaluated for constipation.

Coding Tips and Special Populations

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan or as a result of prompted toileting, assisted toileting, or scheduled toileting.
- If the patient *cannot* voluntarily control the passage of stool, which results in involuntary passage of stool, then he or she is considered incontinent.

- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel as long as the result of releasing the stool was in a commode, toilet, or bedpan.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Examples

1. The day shift nurse notes that Mr. S has a bowel movement every morning, but no episodes of bowel incontinence on her shift during the 3-day assessment period. The nurse checks the medical record and notes no documentation of bowel incontinence on any shift during the 3-day assessment period. The nurse confirms this with the CNA who is assigned to Mr. S to assist him to the toilet.

   Coding: H0400 would be coded 0, Always continent.
   Rationale: The patient was continent of stool throughout the 3-day assessment period.

2. Mr. G has Parkinson's disease and finds it very difficult to get to the bathroom in time to move his bowels. Mr. G made it to the bathroom and defecated in the toilet one time during the 3-day assessment period. Otherwise, he was incontinent of stool multiple times on the other two days during the assessment period.

   Coding: H0400 would be coded 2, Frequently incontinent.
   Rationale: The patient was incontinent of stool for multiple episodes, but had at least one continent bowel movement during the 3-day assessment period.

3. Mr. D has a temporary colostomy and had no episodes of bowel incontinence during the 3-day assessment period.

   Coding: H0400 would be coded 9, Not rated.
   Rationale: The patient has an ostomy and therefore would not be rated.

4. Mrs. F has dementia and is not aware of when she has to go to the bathroom to move her bowels. She soils the bedsheets or her incontinence garment every day during the 3-day assessment period.

   Coding: H0400 would be coded 3, Always incontinent.
   Rationale: The patient had no episodes of continent bowel movements.

5. Mrs. S has multiple sclerosis and has been going through a bowel training program. She gets up to go to the bathroom to defecate daily throughout the 3-day assessment period. The patient had one episode of bowel incontinence during the 3-day assessment period.

   Coding: H0400 would be coded 1, Occasionally incontinent.
   Rationale: The patient was continent of stool except for one episode of bowel incontinence during the 3-day assessment period.

6. Mr. H. has a rectal tube placed with a collection bag due to persistent diarrhea during the 3-day assessment period.

   Coding: H0400 would be coded 9, Not rated.
   Rationale: The patient has a rectal tube or fecal management system, and therefore could not be rated.