Centers for Medicare & Medicaid Services

MDS Tip Sheet: ITEM H3a

Any Scheduled Toileting Plan

MAY 2008

INTRODUCTION	In response to questions related to MDS coding for item H3a, scheduled toileting plan, the following tip sheet has been developed. Use this MDS 2.0 Tip Sheet to better understand MDS coding rationale for this item.
DEFINITION	Item H3a asks you to indicate whether the resident is on a plan for bowel and/or bladder elimination whereby staff members, at scheduled times each day, either take the resident to the toilet room, give the resident a urinal, or remind the resident to go to the toilet during the 14-day observation period. This item includes bowel habit training and/or prompted voiding.
CLARIFICATIONS	There are **three key concepts** to consider when coding item H3a: ▪ **Scheduled** – means performing the activity according to a specific, routine time that has clearly been communicated to the resident (as appropriate) and to caregivers. ▪ **Toileting** – means voiding in a bathroom, commode or other appropriate receptacle (e.g. urinal, bedpan). ▪ **Plan/Program** – means a specific approach that is *organized, planned, documented, monitored and evaluated.* ***All three (3) key components must be present in order to code H3a.***
CODING TIPS	Simply providing incontinence care for a resident does not mean that the resident is on a Toileting Plan. The plan must be based on the ***individualized*** assessment of the resident's need for a toileting program. Consider the following items when evaluating whether a scheduled toileting plan/program may be coded at H3a: 1. The plan should contain an **individualized, resident-specific** toileting schedule – listed either by hours or around the resident's pattern. [**Note**: This does not include generic, every two-hour toileting; nor does it include a plan/schedule that is the same for all incontinent residents.] 2. The **resident's individualized plan** should be clearly communicated and be available and accessible to staff and the resident (as appropriate), via the resident care plan, flow records, verbal and written report, etc. 3. The **resident's response** to the toileting program and subsequent evaluation should be documented in the clinical record and include when changes have been made, depending on the resident's response. 4. If the resident is coded a "4" (totally incontinent) in item H1, then clinical documentation would need to be present to support the appropriateness of coding item H3a.
CODING EXAMPLES	1) Mr. M., who has a diagnosis of CHF and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding **assessment**. After completing this assessment, a plan was developed that called for toileting every hour for four hours after receiving his diuretic, then every three hours until bedtime. The team has communicated this approach to the resident and the care team and has placed these interventions in the care plan. The team will re-evaluate the resident's response to the plan after one month and adjust as needed. This is a scheduled toileting plan. **Code item H3a.** 2) Mrs. H. has a diagnosis of advanced Alzheimer's disease. She is dependent on the staff for her ADLs, does not have the cognitive ability to void in the toilet or other appropriate receptacle, and is totally incontinent. Her voiding **assessment** indicates no pattern to her incontinence. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every two hours while awake and apply a super-absorbent brief at bedtime so as not to disturb her sleep. This is not a scheduled toileting plan. **Do NOT code item H3a.**
FOR MORE HELP	The RAI User's Manual for MDS coding is available on the Centers for Medicare & Medicaid website: http://www.cms.hhs.gov/NursingHomeQualityInits/20_NHQIMDS20.asp. If you need help interpreting MDS coding instructions, contact your State RAI/MDS Coordinator listed in Appendix B of the User's Manual. If you require further assistance, you may submit your question to mdsquestions@cms.hhs.gov.