

SECTION H: BLADDER AND BOWEL

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

H0350. Bladder Continence

Section H	Bladder and Bowel
H0350. Bladder Continence	
Enter Code <input type="text"/>	<p>Bladder continence - Select the one category that best describes the patient.</p> <ul style="list-style-type: none"> 0. Always continent (no documented incontinence) 1. Stress incontinence only 2. Incontinent less than daily (e.g., once or twice during the 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/injuries;
 - 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
 - prompting voiding, or scheduling 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.

DEFINITION

BLADDER INCONTINENCE

The involuntary loss of urine, when there is a loss of control of the evacuation of urine from the bladder, regardless of whether clothing or linens are soiled.

Steps for Assessment

1. Review the patient's medical record for bladder incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the patient if they are capable of reliably reporting their 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.

Complete during the 4-day admission assessment period and within three days of discharge.

- **Code 0, Always continent**, if throughout the 4-day assessment period the patient has been continent of urine, without any episodes of incontinence.
- **Code 1, Stress incontinence only**, if during the 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 assessment period the patient was incontinent of urine once or twice, and had at least one continent void during the assessment period.
- **Code 3, Incontinent daily**, if during the assessment period the patient was incontinent of urine at least once a day, and had at least one continent void during the assessment period.
- **Code 4, Always incontinent**, if during the assessment period the patient had no continent voids and no catheterization.
- **Code 5, No urine output**, if during the assessment period the patient had no urine output (e.g., renal failure, on chronic dialysis with no urine output) for the entire assessment period.
- **Code 9, Not applicable**, if during the assessment period the patient had an indwelling bladder catheter, condom catheter, or ostomy for the entire assessment period.

DEFINITION

STRESS INCONTINENCE

Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

Coding Tips

- If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.
- If a patient with behavioral issues purposefully voids on the floor, this void would not be considered an episode of incontinence.

Examples

1. A patient has had longstanding stress incontinence for many years. When the patient has an upper respiratory infection and is coughing, they involuntarily leak urine. However, during the assessment period, the patient has been free of respiratory symptoms and has not had an episode of incontinence.

Coding: H0350, Bladder Continence would be **coded 0, Always continent**.

Rationale: Even though the patient has a history of intermittent stress incontinence, they were continent during the assessment period.

2. The patient has multi-infarct dementia. The patient was incontinent of urine twice on day 1 of the 4-day admission assessment period, once on day 2, once on day 3, and once on day 4. The patient had some continent voids on days 2 and 3.

Coding: H0350, Bladder Continence would be **coded 3, Incontinent daily**.

Rationale: During the 4-day admission assessment period the patient had at least one episode of urinary incontinence every day and had at least one continent void.

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

Coding: H0350, Bladder Continence would be **coded 4, Always incontinent**.

Rationale: The patient was incontinent of urine during the 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. The patient had one urinary incontinence episode during the assessment period. All other voids were continent because the certified nursing assistant followed a timed toileting schedule to assist the patient to the toilet.

Coding: H0350, Bladder Continence would be **coded 2, Incontinent less than daily**.

Rationale: The patient had one incontinent episode during the assessment period, and had at least one continent void.

5. The patient had an indwelling catheter for urinary drainage that remained in place during the entire assessment period. There were no episodes of urinary incontinence.

Coding: H0350, Bladder Continence would be **coded 9, Not applicable**.

Rationale: The patient was not incontinent because they had an indwelling catheter that was used for urinary drainage for the entire assessment period.

6. The patient was diagnosed with chronic renal failure and had no urinary output during the assessment period.

Coding: H0350, Bladder Continence would be **coded 5, No urine output**.

Rationale: The patient had no urinary output during the assessment period due to chronic renal failure.

7. The patient was continent on the first day of the assessment period, had four urinary incontinence episodes on the second day of the assessment period, and was continent on the third day of the assessment period.

Coding: H0350, Bladder Continence would be **coded 2, Incontinent less than daily**.

Rationale: The patient was incontinent but was not incontinent on each day. While the patient was incontinent four times on one day, the incontinence was confined to one day, the other 3 days the patient did not have any episodes of incontinence.

8. The patient had an incident of incontinence with a small amount of urine leakage when they sneezed during the assessment period. They did not have any other incidents of incontinence.

Coding: H0350, Bladder Continence would be **coded 1, Stress incontinence only**.

Rationale: The patient had an episode of incontinence with a small amount of urine leakage that was associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.

H0400. Bowel Continence

H0400. Bowel Continence	
Enter Code <input type="text"/>	<p>Bowel continence - Select the one category that best describes the patient.</p> <ul style="list-style-type: none"> 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 assessment period

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/injuries; 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 and bedpans.
- 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 patient's medical record for bowel incontinence flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the patient if they are capable of reliably reporting their 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.

Complete during the 4-day admission assessment period.

- **Code 0, Always continent**, if during the 4-day assessment period the patient has been continent for all bowel movements, without any episodes of incontinence.

- **Code 1, Occasionally incontinent**, if during the 4-day assessment period the patient was incontinent for bowel movement once but also had at least one continent bowel movement. This includes incontinence of any amount of stool at any time.
- **Code 2, Frequently incontinent**, if during the 4-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 4-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 4-day assessment period the patient had an ostomy or other device for bowel elimination, or the patient did not have a bowel movement during the entire 4 days. Note that patients who have not had a bowel movement for 4 days should be evaluated for constipation.

Coding Tips

- Being continent has to do with the ability to voluntarily release stool in a commode, toilet, or bedpan or as a result of planned bowel movement as part of a bowel program.
- 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 occurred within a reasonable amount of time.
- 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 the patient has a bowel movement every morning, but no episodes of bowel incontinence on the nurse's shift during the 4-day assessment period. The nurse checks the medical record and notes no documentation of bowel incontinence on any shift during the 4-day assessment period. The nurse confirms this with the certified nursing assistant who is assigned to the patient to assist them to the toilet.

Coding: H0400, Bowel Continence would be **coded 0, Always continent**.

Rationale: The patient was continent of stool throughout the 4-day assessment period.

2. The patient has Parkinson's disease and finds it very difficult to get to the bathroom in time to move their bowels. The patient made it to the bathroom and defecated in the toilet one time during the 4-day assessment period. Otherwise, the patient was incontinent of stool multiple times on the other 3 days during the assessment period.

Coding: H0400, Bowel Continence 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 4-day assessment period.

3. The patient has a temporary colostomy and had no episodes of bowel incontinence during the 4-day assessment period.

Coding: H0400, Bowel Continence would be **coded 9, Not rated**.

Rationale: The patient has an ostomy during the entire 4-day assessment period and therefore would not be rated.

4. The patient has dementia and is not aware of when they have to go to the bathroom to move their bowels. The patient soils the bedsheets or their incontinence garment every day during the 4-day assessment period. They have not had any continent episodes.

Coding: H0400, Bowel Continence would be **coded 3, Always incontinent**.

Rationale: The patient had no episodes of continent bowel movements.

5. The patient has multiple sclerosis and has been going through a bowel training program. They get up to go to the bathroom to defecate daily throughout the 4-day assessment period. The patient had one episode of bowel incontinence during the 4-day assessment period.

Coding: H0400, Bowel Continence would be **coded 1, Occasionally incontinent**.

Rationale: The patient was continent of stool except for one episode of bowel incontinence during the 4-day assessment period.

6. The patient has a rectal tube placed with a collection bag due to persistent diarrhea during the 4-day assessment period.

Coding: H0400, Bowel Continence would be **coded 9, Not rated**.

Rationale: The patient has a rectal tube or fecal management system during the entire 4-day assessment period and therefore could not be rated.