



Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training



*Section H:
Bladder and Bowel*

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Section H: Objectives

- Define Section H: Bladder and Bowel.
- Explain new items and/or changes between LTCH CARE Data Set v2.01 and v3.00.
- Explain the intent of Section H.
- Discuss coding instructions and needed information for items.
- Accurately code scenario(s).

Section H: New Items and Changes

NEW:

- H0350, Bladder Continence
- Complete only if:
 - A0250 = 01 Admission.
 - A0250 = 10 Planned Discharge.
- H0400, Bowel Continence currently exists on the LTCH CARE Data Set
 - A0250 = 01 Admission.
 - No changes to this item.

Section H: Intent and Rationale

INTENT: To gather information on urinary and bowel continence.

RATIONALE: Bladder and bowel incontinence can:

- Increase risk for longer lengths of stay.
- Lead to skin rashes, breakdown, and development and/or worsening of pressure ulcers.
- Increase risk for falls and injuries resulting from attempts to reach a toilet unassisted.
- Potentially be resolved or minimized by identifying and treating underlying potentially reversible conditions.
- Be socially embarrassing and lead to increased feelings of dependency and social isolation.

Section H: Definitions

CONTINENCE: The ability to voluntarily release urine or stool in a commode, toilet, or bedpan.

INCONTINENCE: The involuntary passage of urine or stool.

SECTION H: H0350. Bladder Continence

STEPS FOR ASSESSMENT:

- Review the medical record:
 - Bladder incontinence records or flow sheets.
 - Nursing assessments and progress notes.
 - Physician history and physical examination.
- Interview the patient or family.
- Ask direct care staff.

Section H: H0350

H0350. Bladder Continence (3-day assessment period.)	
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 only2. 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 incontinent5. No urine output (e.g., renal failure)9. Not applicable (e.g., indwelling catheter)

Applies to Admission and Planned Discharge Assessments

Section H: H0350 (cont.)

CODING INSTRUCTIONS:

- **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.

Section H: H0350 (cont.)

CODING INSTRUCTIONS FOR SPECIAL POPULATIONS:

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

Section H: H0350 Coding Scenario (1)

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.

How would you code H0350?
What is your rationale?

Section H: H0350 Coding Scenario (1)

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.

Section H: H0350 Coding Scenario (2)

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 Mrs. T to the toilet.

How would you code H0350?

What is your rationale?

Section H: H0350 Coding Scenario (2)

CODING: H0350 would be coded **2, Incontinent less than daily.**

RATIONALE: The patient had one incontinent episode during the 3-day assessment period.

Section H: H0350 Coding Scenario (3)

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

How would you code H0350?
What is your rationale?

Section H: H0350 Coding Scenario (3)

CODING: H0350 would be coded **9, Not applicable.**

RATIONALE: The patient was not incontinent because she had an indwelling catheter.

SECTION H: H0400. Bowel Continence

STEPS FOR ASSESSMENT:

- Review the medical record:
 - Bowel incontinence flow sheets.
 - Nursing assessments and progress notes.
 - Physician history and physical examination.
- Interview the patient or family.
- Ask direct care staff.

Section H: H0400

H0400. Bowel Continence (3-day assessment period)	
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 continent1. 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

Applies to Admission Assessment only

Section H: H0400 (cont.)

CODING INSTRUCTIONS:

- **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 movements 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 movements 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.

Section H: H0400 (cont.)

CODING INSTRUCTIONS FOR SPECIAL POPULATIONS:

- Patients who require assistance to maintain the passage of stool via artificial initiation, such as manual stimulation, rectal suppositories, or enemas, would be considered continent of bowel as long as the result of releasing stool was in a commode, toilet, or bedpan.

Section H: H0400 Coding Scenario

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 2 days during the assessment period.

How would you code H0400?

What is your rationale?

Section H: H0400 Coding Scenario

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.

Section H: Summary

- Section H gathers information on urinary and bowel incontinence.
- H0350, Bladder Continence is a new item on the LTCH CARE Data Set v3.00.
- If intermittent catheterization is used, code incontinence level based on continence between catheterizations.
- Interview the patient, family, or significant others regarding the patient's incontinence and ask direct care staff who routinely work with the patient.

Section H: Action Plan

- Practice coding a variety of scenarios with staff.