

Section H

Bladder and Bowel

Objectives

- State the intent of Section H Bladder and Bowel.
- Describe how to conduct the assessment for urinary incontinence.
- Describe how to conduct the assessment for bowel incontinence.
- Code Section H correctly and accurately.

Intent of Section H

- To gather information on:
 - Use of bowel and bladder appliances
 - Use of and response to urinary toileting programs
 - Urinary and bowel continence
 - Bowel toileting programs
 - Bowel patterns
- Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment and services.

Item H0100

Appliances

H0100 Importance₁

- External catheters should:
 - Fit well and be comfortable
 - Minimize leakage
 - Maintain skin integrity
 - Promote resident dignity
- Indwelling catheters should not be used unless there is valid medical justification.
- Assessment for indwelling catheters should include:
 - Risk and benefits
 - Anticipated duration of use
 - Consideration of complications

H0100 Importance₂

- Complications can include:
 - Increased risk of urinary tract infection
 - Blockage of the catheter
 - Expulsion of the catheter
 - Pain
 - Discomfort
 - Bleeding
- Ostomies should be free of redness, tenderness, excoriation, and breakdown.
- Appliances should fit well, be comfortable, and promote resident dignity.

H0100 Conduct the Assessment

- Examine the resident to note the presence of any urinary or bowel appliances.
- Review the medical record for current or past use of urinary or bowel appliances.
 - Include bladder and bowel records.

H0100 Assessment Guidelines

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter only.
- Condom catheters and external urinary pouches are commonly used intermittently or at night only.
 - This use should be coded as external catheter.
- Do not code gastrostomies or other feeding ostomies in this section.
- Only appliances used for elimination are coded here.

H0100 Coding Instructions

- Check each appliance used during the look-back period.

H0100. Appliances	
↓ Check all that apply	
<input type="checkbox"/>	A. Indwelling catheter (including suprapubic catheter and nephrostomy tube)
<input checked="" type="checkbox"/>	B. External catheter
<input type="checkbox"/>	C. Ostomy (including urostomy, ileostomy, and colostomy)
<input checked="" type="checkbox"/>	D. Intermittent catheterization
<input type="checkbox"/>	Z. None of the above

Item H0200

**Urinary Toileting
Program**

H0200 Importance

- Determining the type of urinary incontinence:
 - Allows staff to provide more individualized programming or interventions
 - Enhances the resident's quality of life and functional status.
- Many incontinent residents respond to a toileting program:
 - Especially during the day
 - Includes residents with dementia

H0200 Toileting Program₁

- H0200 captures three aspects of a resident's toileting program:
 - H0200A Toileting Program Trial:
Whether a toileting program has been attempted
 - H0200B Toileting Program Trial Response:
Resident's response to any trial program
 - H0200C Current Toileting Program:
Whether a current toileting program is being used to manage a resident's incontinence

H0200 Toileting Program₂

- Toileting program refers to a specific approach:
 - Organized, planned, documented, monitored, and evaluated
 - Consistent with nursing home policies and procedures and current standards of practice
- Toileting program does not refer to:
 - Simply tracking continence status
 - Changing pads or wet garments
 - Random assistance with toileting or hygiene

H0200A Toileting Program Trial Conduct the Assessment₁

- Review the medical record.
 - Identify evidence of a trial of individualized, resident-centered toileting program.
 - Include observations of at least 3 days of toileting patterns.
 - Document results in a bladder record or voiding diary.
- Toileting programs may have different names.
 - Habit training/ scheduled voiding
 - Bladder rehabilitation/ bladder retraining
 - Prompted voiding

H0200A Toileting Program Trial

Conduct the Assessment₂

- Review records of voiding patterns over several days for residents experiencing incontinence.
 - Frequency
 - Volume
 - Duration
 - Nighttime or daytime
 - Quality of stream

H0200A Assessment Guidelines₁

- Look-back period for H0200A:
 - Most recent admission/ readmission assessment
 - Most recent prior assessment
 - When incontinence was first noted
- Voiding records:
 - Help detect urinary patterns or intervals between incontinence episodes.
 - Facilitate providing care to avoid or reduce the frequency of episodes.

H0200A Assessment Guidelines₂

- Simply tracking continence status is not considered a trial of an individualized, resident-centered toileting program.
- Residents should be re-evaluated whenever there is a change in:
 - Cognition
 - Physical ability
 - Urinary tract function

H0200A Coding Instructions

- Code **0. No** for residents who:
 - Are continent with or without toileting assistance
 - Use a permanent catheter or ostomy
 - Prefer not to participate in a trial
- Code **1. Yes** for residents who underwent a trial at least once.

H0200. Urinary Toileting Program

Enter Code

A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility?

0. No → Skip to H0300, Urinary Continence/Reentry or Similar
1. Yes → Continue to H0200A
9. Unable to determine

0 **No** → Skip to H0300, Urinary Continence/Reentry or Similar
1 **Yes** → Continue to H0200A
9 **Unable to determine** →

Response - What was the reason?

H0200B Toileting Program Trial Response Conduct the Assessment

- Review the resident's responses as recorded during the toileting trial.
- Note any change:
 - Number of incontinence episodes
 - Degree of wetness the resident experiences
- Look-back period for H0200B (same as H0200A):
 - Most recent admission/ readmission assessment
 - Most recent prior assessment
 - When incontinence was first noted

H0200B Coding Instructions

- Code **0**. if incontinence did not decrease.
- Code **1**. if frequency decreased but resident is still incontinent.
- Code **2**. if resident becomes completely continent of urine.
- Code **9**. if no information or trial is in progress.

Enter Code

B. Response - What was the resident's response to the trial program?

0.	No improvement
1.	Decreased wetness
2.	Completely dry (continent)
9.	Unable to determine or trial in progress

Response - What was the resident's response to the trial program?

0 No improvement

1 Decreased wetness

2 Completely dry (continent)

9 Unable to determine or trial in progress

urrent toileting pro

H0200C Current Toileting Program Conduct the Assessment₁

- The look-back period is **7 days**.
- Review the medical record for evidence of a toileting program being used to manage incontinence.
- Note the number of days that the toileting program was implemented or carried out during the look-back period.

H0200C Current Toileting Program

Conduct the Assessment₂

- Look for documentation of 3 requirements:
 - Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern
 - Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report
 - Notations of the resident's response to the toileting program and subsequent evaluations, as needed

H0200C Coding Instructions

- Code **0. No** if toileting program is used less than 4 days during the look-back period.
- Code **1. Yes** for residents who are managed 4 or more days of the look-back period.

Enter Code C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. No
1. Yes

0 No
1 Yes

Coding a Trial in Progress

- If a resident is currently undergoing a toileting program trial:
 - Code H0200A as **1. Yes**, a trial toileting program is attempted.
 - Code H0200B as **9**. Unable to determine or trial in progress.
 - Code H0200C as **1. Yes** for current toileting program.

H0200 Scenario #1

- 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/ diary 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.
- Facility policy is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb her sleep.

H0200 Scenario #1 Coding

- Code H0200A as **1. Yes.**
- Code H0200B as **0. No improvement.**
- Code H0200C as **0. No.**

H0200. Urinary Toileting Program	
Enter Code 1	A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility? to H0300, Urinary Continence Continue to H0200B, Response Determine → Skip to H0200C, Current toileting program or trial
Enter Code 0	B. What was the resident's response to the trial program? Improvement Continence Dry (continent) Determine or trial in progress
Enter Code 0	C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently in progress to manage the resident's urinary continence?
Enter Code 0	

H0200 Scenario #2₁

- Mr. M., who has a diagnosis of congestive heart failure (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/ diary.
- After completing the assessment, it was determined that incontinence episodes could be reduced.

H0200 Scenario #2₂

- A plan was developed that called for toileting:
 - Every hour for 4 hours after receiving his 8 a.m. diuretic
 - Then every 3 hours until bedtime at 9 p.m.
- The team has communicated this approach to the resident.
- The care team has placed these interventions in the care plan.
- The team will reevaluate the resident's response to the plan after 1 month and adjust as needed.

H0200 Scenario #2 Coding

- Code H0200A as **1**. Yes.
- Code H0200B as **9**. Unable to determine or trial in progress.
- Code H0200C as **1**. current toileting program or trial.

H0200. Urinary Toileting Program	
Enter Code 1	A. Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/reentry or since urinary incontinence was noted in this facility? to H0300, Urinary Continence Continue to H0200B, Response Determine → Skip to H0200C, Current toileting program or trial
Enter Code 9	B. What was the resident's response to the trial program? Wetness Dry (continent) Determine or trial in progress
Enter Code 1	C. Is a toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently in place to manage the resident's urinary continence?

Item H0300

Urinary Incontinence

H0300 Importance

- Incontinence can
 - Interfere with participation in activities.
 - Be socially embarrassing and lead to increased feelings of dependency.
 - Increase risk of long-term institutionalization.
 - Increase risk of skin rashes and breakdown.
 - Increased risk of repeated urinary tract infections.
 - Increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

H0300 Conduct the Assessment

- Review the medical record.
 - Bladder or incontinence records or flow sheets
 - Nursing assessments and progress notes
 - Physician history
 - Physical examination
- Interview the resident (if capable of reporting).
- Speak with family members or significant others if resident is not able to report on continence.
- Ask direct care staff on all shifts about incontinence episodes.

H0300 Assessment Guidelines

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

H0300 Coding Instructions

- Code according to the number of episodes of incontinence that occur during the look-back period.

H0300. Urinary Continence

Urinary continence - Select the number of episodes of urinary incontinence that occurred during the look-back period.

Enter Code	Urinary continence - Select the number of episodes of urinary incontinence that occurred during the look-back period.
<input type="checkbox"/>	0. Always continent
	1. Occasionally incontinent (less than 7 episodes of incontinent voiding)
	2. Frequently incontinent (7 or more episodes of incontinent voiding during a 7 day period)
	3. Always incontinent (no episode of continence during the look-back period)
	9. Not rated, resident had a catheter

H0300 Scenario

- An 86-year-old female resident has had longstanding stress-type incontinence for many years.
- When she has an upper respiratory infection and is coughing, she involuntarily loses urine.
- However, during the current 7-day look-back period, the resident has been free of respiratory symptoms and has not had an episode of incontinence.

H0300 Scenario Coding

- H0300 would be coded **0**. Always continent.
- Even though the resident has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

H0300. Urinary Continence	
Enter Code	Urinary continence - Select the one category that best describes the resident
<input type="text" value="0"/>	0. Always continent
	1. Occasionally incontinent (less than 7 episodes of incontinence)
	2. Frequently incontinent (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
	3. Always incontinent (no episodes of continent voiding, urinary ostomy, or no urine output for the entire 7 days)
	9. Not rated, resident had a

Enter Code	Urinary continence - Select the
<input type="text" value="0"/>	0. Always continent
	1. Occasionally incontinent
	2. Frequently incontinent (
	3. Always incontinent (no e
	9. Not rated , resident had a

H0300 Practice #1

- A resident with multi-infarct dementia:
 - Is incontinent of urine on three occasions on day one of observation
 - Is continent of urine in response to toileting on days two and three
 - Has one urinary incontinence episode during each of the nights of days four, five, six, and seven of the look-back period.

How should H0300 be coded?

- A. Code **0**. Always continent
- B. Code **1**. Occasionally incontinent
- C. Code **2**. Frequently incontinent
- D. Code **3**. Always incontinent
- E. Code **9**. Not rated

H0300 Practice #1 Coding

- The correct code is **2**. Frequently incontinent.
- The resident had seven documented episodes of urinary incontinence over the look-back period.
- The criterion for “frequent” incontinence has been set at seven or more episodes over the 7-day look-back period with at least one continent void.

H0300 Practice #2

- A resident with Parkinson's disease is severely immobile, and cannot be transferred to a toilet.
- He is unable to use a urinal and is managed by adult briefs and bed pads that are regularly changed.
- He did not have a continent void during the 7-day look-back period.

How should H0300 be coded?

- A. Code **0**. Always continent
- B. Code **1**. Occasionally incontinent
- C. Code **2**. Frequently incontinent
- D. Code **3**. Always incontinent
- E. Code **9**. Not rated

H0300 Practice #2 Coding

- The correct code is **3**. Always incontinent.
- The resident has no urinary continent episodes and cannot be toileted due to severe disability or discomfort.
- Incontinence is managed by a check and change in protocol.

Item H0400

Bowel Continence

H0400 Importance

- Bowel incontinence
 - Interferes with participation in activities.
 - Is socially embarrassing and can lead to increased feelings of dependency.
 - Increases risk of long-term institutionalization.
 - Increases risk of skin rashes and breakdown.
 - Increases the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

H0400 Conduct the Assessment

- Review the medical record.
 - Bowel records and incontinence flow sheets
 - Nursing assessments and progress notes
 - Physician history
 - Physical examination
- Interview the resident (if capable of reporting).
- Speak with family members or significant others if resident is not able to report on continence.
- Ask direct care staff on all shifts about incontinence episodes.

H0400 Assessment Guidelines

- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

H0400 Coding Instructions

- Code according to the number of episodes of bowel incontinence that occur during the look-back period.

H0400. Bowel Continence

Enter Code **Bowel continence - Select the one category that best describes the resident's bowel movement**

0	Always continent
1	Occasionally incontinent (one episode)
2	Frequently incontinent (2 or more episodes)
3	Always incontinent (no episodes)
9	Not rated, resident had a bowel movement

0 Always continent
1 Occasionally incontinent (one episode)
2 Frequently incontinent (2 or more episodes)
3 Always incontinent (no episodes)
9 Not rated, resident had a bowel movement

Item H0500

**Bowel Toileting
Program**

H0500 Importance

- A systematically implemented bowel toileting program may
 - Decrease or prevent bowel incontinence.
 - Minimize or avoid the negative consequences of incontinence.
- Many incontinent residents respond to a bowel toileting program.

H0500 Conduct the Assessment

- Review the medical record for evidence of a bowel toileting program.
- Look for documentation of 3 requirements:
 - Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern
 - Evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report
 - Notations of the resident's response to the toileting program and subsequent evaluations, as needed

H0500 Coding Instructions

- Code according to whether a toileting program is used to manage bowel continence.

H0500. Bowel Toileting Program	
Enter Code	Is a toileting program currently being used to manage the resident's bowel continence?
<input type="checkbox"/>	0. No 1. Yes

0 No
1 Yes

Item H0600

Bowel Patterns

H0600 Importance

- Severe constipation can cause:
 - Abdominal pain
 - Anorexia
 - Vomiting
 - Bowel incontinence
 - Delirium
- Constipation can lead to fecal impaction if unaddressed.

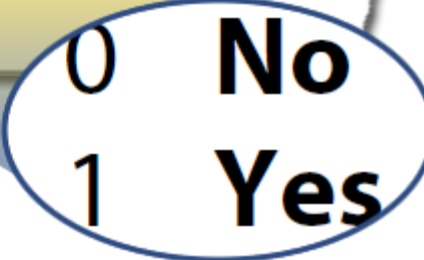
H0600 Conduct the Assessment

- Review the medical record for evidence of constipation.
 - Bowel records or flow sheets
 - Nursing assessments and progress notes
 - Physician history
 - Physical examination
- Interview the resident.
- Speak with family members or significant others if resident is not able to report on bowel habits.
- Ask direct care staff about problems with constipation.

H0600 Coding Instructions

- Code according to whether a resident shows signs of constipation during the look-back period.

H0600. Bowel Patterns	
Enter Code <input type="checkbox"/>	Constipation present? 0. No 1. Yes



Section H

Summary

Section H Summary

- Focuses on a resident's bladder and bowel status.
- Includes documenting the level of incontinence, if any as well as constipation.
- Record any toileting programs established to address incontinence issues.
- Toileting programs include only programs organized and planned to resolve or minimize causes or episodes of incontinence.