



**Minimum Data Set (MDS) 3.0  
Instructor Guide**

# 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.



### **Methodology**

This lesson uses lecture and scenario-based examples and practice.

### **Training Resources**

- Instructor Guide
- Slides 1 - 57

### **Instructor Preparation**

- Review the Instructor Guide for this lesson.
- Review learning objectives for the lesson.
- Rehearse with slide presentation.

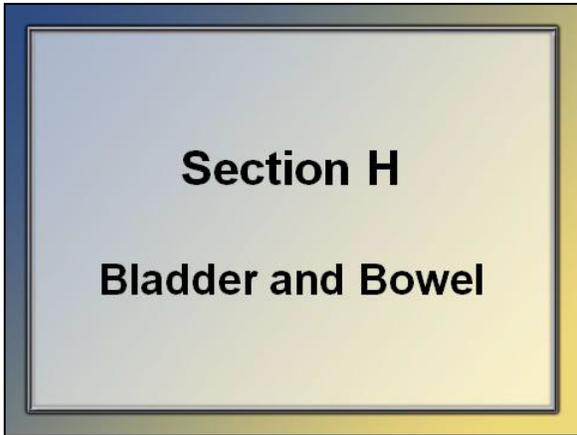


SLIDES	INSTRUCTIONAL GUIDANCE
<b>Instructor Notes</b>	
<b>Instructor Notes</b>	

**Instructor Notes**

Direct participants to turn to Section H in the MDS 3.0 instrument.

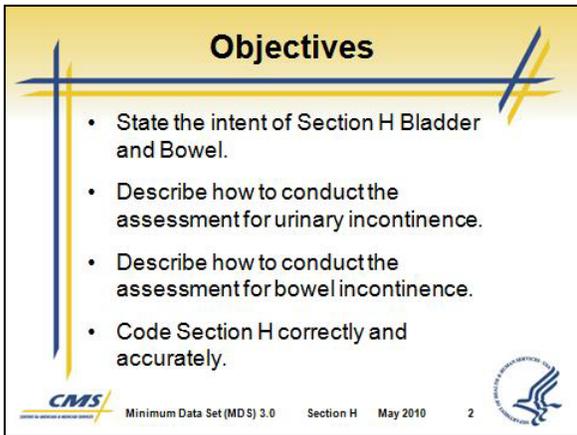
**Instructor Notes**



Slide 1

**I. Introduction/Objectives**

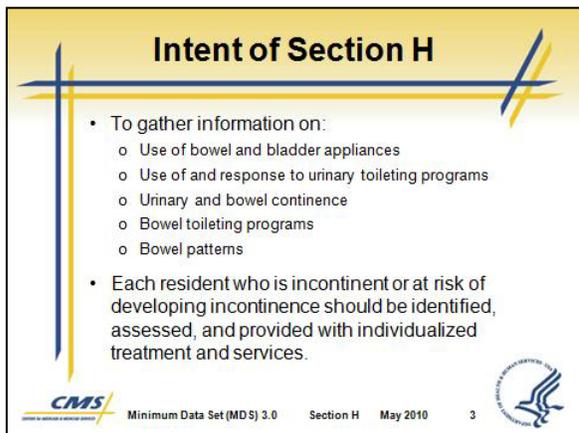
- A. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment ( medications, non-medicinal treatments and/or devices) and services to achieve or maintain as normal elimination function as possible.
- B. In this lesson we will look at the assessment of a resident’s bladder and bowel status.



Slide 2

- C. 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.

**SLIDES**



Slide 3

**INSTRUCTIONAL GUIDANCE**

**D. Intent of Section H**

1. The intent of the items in this section is to gather information on:
  - a. Use of bowel and bladder appliances
  - b. Use of and response to urinary toileting programs
  - c. Urinary and bowel continence
  - d. Bowel toileting programs
  - e. Bowel patterns
2. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medicinal treatments and/ or devices) and services to achieve or maintain as normal elimination function as possible.

**II. Item H0100 Appliances**

- A. It is important to know what appliances are in use and the history and rationale for such use.



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## SLIDES

**H0100 Importance<sub>1</sub>**

- 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

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## INSTRUCTIONAL GUIDANCE

## B. H0100 Importance

1. External catheters should:
  - a. Fit well and be comfortable
  - b. Minimize leakage
  - c. Maintain skin integrity
  - d. Promote resident dignity
2. Indwelling catheters should not be used unless there is valid medical justification.
3. Assessment should include:
  - a. Consideration of the risk and benefits of an indwelling catheter
  - b. Anticipated duration of use
  - c. Consideration of complications resulting from the use of an indwelling catheter
4. Complications can include:
  - a. Increased risk of urinary tract infection
  - b. Blockage of the catheter with associated bypassing of urine
  - c. Expulsion of the catheter
  - d. Pain
  - e. Discomfort
  - f. Bleeding
5. Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown.
6. Appliances should fit well, be comfortable, and promote resident dignity.

**H0100 Importance<sub>2</sub>**

- 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.

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SLIDES		INSTRUCTIONAL GUIDANCE	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Indwelling Catheter</b></p> <p>A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>External Catheter</b></p> <p>Device attached to the shaft of the penis like a condom for males or a receptacle pouch that fits around the labia majora for females and connected to a drainage bag.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Nephrostomy Tube</b></p> <p>A catheter inserted through the skin into the kidney in individuals with an abnormality of the ureter (the fibromuscular tube that carries urine from the kidney to the bladder) or the bladder.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Ostomy</b></p> <p>Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Urostomy</b></p> <p>A stoma for the urinary system used in cases where long-term drainage of urine through the bladder and urethra is not possible, e.g. after extensive surgery or in case of obstruction.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Ileostomy</b></p> <p>A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.</p>	<b>Notes</b>	
		<b>Instructor Notes</b>	

## SLIDES

## INSTRUCTIONAL GUIDANCE

## Instructor Notes

**Colostomy**

A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

## Instructor Notes

## Instructor Notes

**Intermittent Catheterization**

Sterile insertion and removal of a catheter through the urethra for bladder drainage. Does not include a one-time catheterization to obtain a urine specimen during the look-back period.

## Instructor Notes

**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.

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## C. H0100 Conduct the Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.
2. Review the medical record for current or past use of urinary or bowel appliances.
  - a. 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.

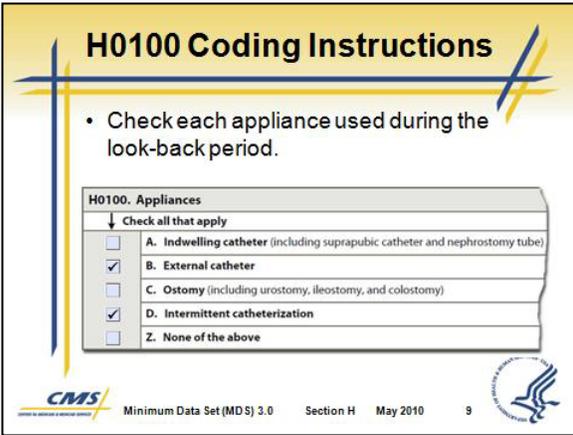
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## D. H0100 Assessment Guidelines

1. Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
2. In men, condom catheters, and in females, external urinary pouches, are commonly used intermittently or at night only.
  - a. This use should be coded as external catheter.

**SLIDES** **INSTRUCTIONAL GUIDANCE**

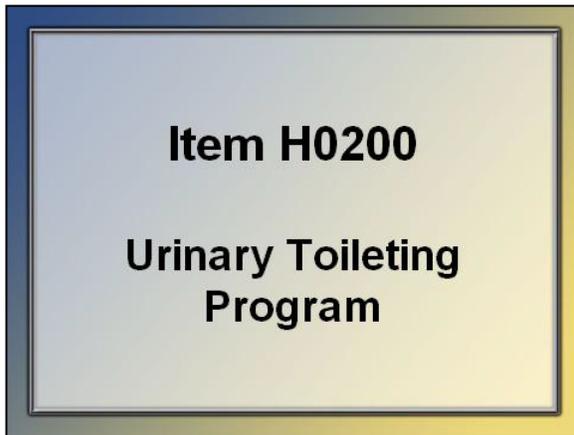


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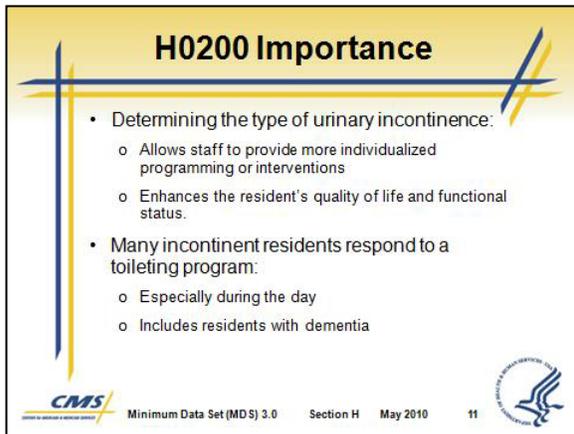
3. Do not code gastrostomies or other feeding ostomies in this section.
  4. Only appliances used for elimination are coded here.
- E. H0100 Coding Instructions
1. Check next to each appliance that was used at any time in the past 7 days.
  2. Select **None of the above** if none of the appliances A-D were used in the past 7 days.
    - **H0100A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
    - **H0100B. External catheter**
    - **H0100C. Ostomy** (including urostomy, ileostomy, and colostomy)
    - **H0100D. Intermittent catheterization**
    - **H0100Z. None of the above**

<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Suprapubic Catheter</b></p> <p>An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.</p>
<b>Instructor Notes</b>	

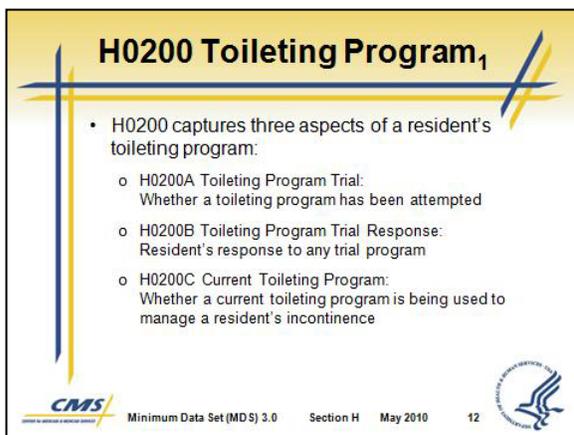
## SLIDES



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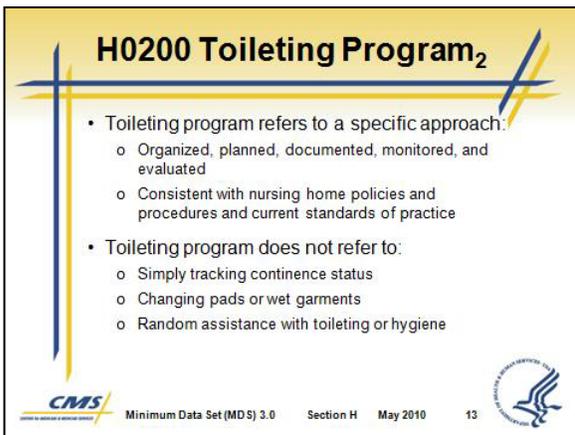
## INSTRUCTIONAL GUIDANCE

### III. Item H0200 Urinary Toileting Program

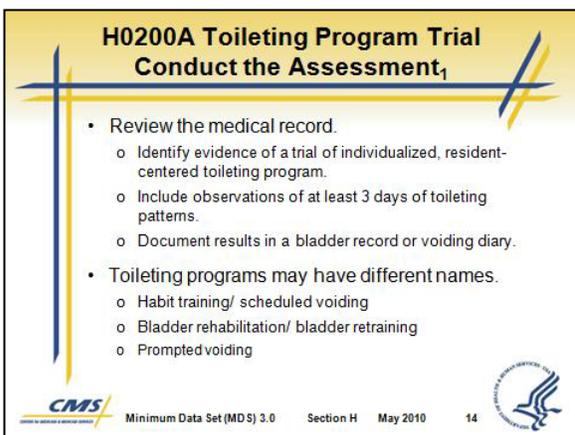
- A. An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
  
- B. H0200 Importance
  1. Determining the type of urinary incontinence:
    - a. Allows staff to provide more individualized programming or interventions.
    - b. Enhances the resident's quality of life and functional status
  2. Many incontinent residents respond to a toileting program:
    - a. Especially during the day
    - b. Includes residents with dementia
  
- C. H0200 captures three aspects of a resident's toileting program:
  1. H0200A Toileting Program Trial documents whether a toileting program has been attempted for this resident since urinary incontinence was noted in this facility.
  2. H0200B Toileting Program Trial Response documents a resident's response to any trial program identified in H0200A.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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3. H0200C Current Toileting Program documents whether a current toileting program is being used to manage a resident's urinary incontinence.

D. What qualifies as a toileting program?

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

E. H0200A Conduct the Assessment

1. Remember that H0200A Toileting Program Trial documents if the resident has participated in a trial toileting program for urinary incontinence.
2. Review the medical record.
  - a. Identify evidence of a trial of individualized, resident-centered toileting program.
  - b. Include observations of at least 3 days of toileting patterns with prompting to toilet.

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- c. Document results in a bladder record or voiding diary.
- 3. Toileting programs may have different names.
  - a. Habit training/ scheduled voiding
  - b. Bladder rehabilitation/ bladder retraining
  - c. Prompted voiding

Instructor Notes
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<b>Notes</b>	<p><b>Habit Training/ Scheduled Voiding</b></p> <p>A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident’s voiding habits or needs.</p>	<b>Notes</b>
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Instructor Notes
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Instructor Notes
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<b>Notes</b>	<p><b>Bladder Rehabilitation/ Bladder Retraining</b></p> <p>A behavioral technique that requires the resident to resist or inhibit the sensation of urgency (the strong desire to urinate), to postpone or delay voiding, and to urinate according to a timetable rather than to the urge to void.</p>	<b>Notes</b>
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Instructor Notes
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<b>Notes</b>	<p><b>Prompted Voiding</b></p> <p>Prompted voiding includes (1) regular monitoring with encouragement to report continence status, (2) using a schedule and prompting the resident to toilet, and (3) praise and positive feedback when the resident is continent and attempts to toilet.</p>	<b>Notes</b>
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Instructor Notes
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**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**H0200A Toileting Program Trial  
Conduct the Assessment<sub>2</sub>**

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

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4. Review records of voiding patterns over several days for residents experiencing incontinence.
  - a. Frequency
  - b. Volume
  - c. Duration
  - d. Nighttime or daytime
  - e. Quality of stream

**H0200A Assessment Guidelines<sub>1</sub>**

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

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

**H0200A Assessment Guidelines<sub>2</sub>**

- 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:
  - o Cognition
  - o Physical ability
  - o Urinary tract function

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

## SLIDES

**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

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 coded (initial facility)?

0 No → Skip to H0300, Urinary Continence

1 Yes → Continue to H0200B, Current Toileting Program or Trial

9 Unable to determine →

Response - What was the

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## INSTRUCTIONAL GUIDANCE

## G. H0200A Coding Instructions

- **Code 0. No**

If for any reason the resident did not undergo a toileting trial.

This includes residents who are continent of urine with or without toileting assistance, or who use a permanent catheter or ostomy, as well as residents who prefer not to participate in a trial.

Skip to Urinary Continence item (H0300).

*Emphasize new skip pattern here.*

- **Code 1. Yes**

For residents who underwent a trial of an individualized, resident-centered toileting program at least once since admission/ readmission, prior assessment, or when urinary incontinence was first noted.

- **Code 9. Unable to determine**

If records cannot be obtained to determine if a trial toileting program has been attempted.

If coded **9**, skip H0200B and go to H0200C, Current Toileting Program or Trial.

*Emphasize new skip pattern here.*

**SLIDES**

**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

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**INSTRUCTIONAL GUIDANCE**

H. H0200B Conduct the Assessment

- Remember that H0200B documents the Toileting Program Trial Response.
- 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:
  - Most recent admission/ readmission assessment
  - Most recent prior assessment
  - When incontinence was first noted

I. H0200B Coding Instructions

- Code 0. No improvement**  
If the frequency of resident's urinary incontinence did not decrease during the toileting trial
- Code 1. Decreased wetness**  
If the resident's urinary incontinence frequency decreased, but the resident remained incontinent  
There is no quantitative definition of improvement.

**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.

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

- 0 No improvement
- 1 Decreased wetness
- 2 Completely dry (continent)
- 9 Unable to determine

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## SLIDES

## INSTRUCTIONAL GUIDANCE

However, the improvement should be clinically meaningful – for example, having at least one less incontinent void per day than before the toileting program was implemented.

- **Code 2. Completely dry (continent)**

If the resident becomes completely continent of urine, with no episodes of urinary incontinence during the toileting trial (For residents who have undergone more than one toileting program trial during their stay, use the most recent trial to complete this item.)

- **Code 9. Unable to determine or trial in progress**

If the response to the toileting trial cannot be determined because information cannot be found or because trial is still in progress

**H0200C Current Toileting Program  
Conduct the Assessment<sub>1</sub>**

- 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.

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J. H0200C Conduct the Assessment

1. The look-back period for H0200C is **7 days**.
2. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period.
3. Note the number of days that the toileting program was implemented or carried out during the look-back period.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**H0200C Current Toileting Program Conduct the Assessment<sub>2</sub>**

- 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

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4. Look for documentation of 3 requirements:
  - a. Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique voiding pattern
  - b. 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
  - c. 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.

Item Code: C. Current toileting program or total - 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**

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**K. H0200C Coding Instructions**

- **Code 0. No**  
If an individualized, resident-centered toileting program (i.e., prompted voiding, scheduled toileting or bladder training) is used less than 4 days of the 7-day look-back period to manage the resident's urinary continence
- **Code 1. Yes**  
For residents who are being managed, during 4 or more days of the 7-day look-back period, with some type of systematic toileting program (i.e., bladder rehabilitation/bladder retraining, prompted voiding, habit training/scheduled voiding)

## SLIDES

## INSTRUCTIONAL GUIDANCE

**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.

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**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.

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Some residents prefer to not be awakened to toilet. If that resident, however, is on a toileting program during the day, code **1. Yes**.

## L. Coding for a Trial in Progress

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

## M. H0200 Scenario #1

1. Mrs. H. has a diagnosis of advanced Alzheimer's disease.
2. 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.
3. Her voiding assessment/ diary indicates no pattern to her incontinence.
4. Her care plan states that due to her total incontinence, staff should follow the facility standard policy for incontinence.
5. 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.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**H0200 Scenario #1 Coding**

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

H0200. Urinary Toileting Program  
Indicates whether a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on the resident's behalf or if the resident's incontinence was related to the toilet.  
The resident's response to the program is:  
 Enter Code  
 1  
Is there any improvement in the resident's incontinence as a result of the program?  
 Enter Code  
 0  
Is the resident's response to the program?  
 Enter Code  
 0  
Is the resident's incontinence related to the program or total? (A toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) cannot be attempted if the resident's urinary incontinence is:

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N. H0200 Scenario #1 Coding

1. H0200A would be coded as **0. No.**
2. H0200B would be skipped.
3. H0200C would be skipped.
4. Based on this resident's voiding assessment/ diary, there was no pattern to her incontinence.
5. Therefore, H0200A would be coded as **0. No.**
6. Due to total incontinence, a toileting program is not appropriate for this resident.
7. Since H0200A is coded **0. No**, skip to H0300 Urinary Contenance.

**H0200 Scenario #2<sub>1</sub>**

- 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. Urinary Toileting Program  
Indicates whether a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on the resident's behalf or if the resident's incontinence was related to the toilet.  
The resident's response to the program is:  
 Enter Code  
 1  
Is there any improvement in the resident's incontinence as a result of the program?  
 Enter Code  
 0  
Is the resident's response to the program?  
 Enter Code  
 0  
Is the resident's incontinence related to the program or total? (A toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) cannot be attempted if the resident's urinary incontinence is:

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O. H0200 Scenario #2

1. 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.
2. The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment/ diary.
3. After completing the assessment, it was determined that incontinence episodes could be reduced.

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**H0200 Scenario #2<sub>2</sub>**

- 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.

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4. A plan was developed and implemented that called for toileting:
  - a. Every hour for 4 hours after receiving his 8 a.m. diuretic
  - b. Then every 3 hours until bedtime at 9 p.m.
5. The team has communicated this approach to the resident.
6. The care team has placed these interventions in the care plan.
7. 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.**



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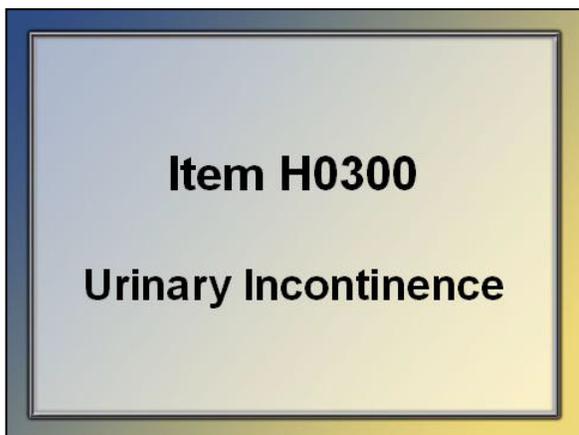
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P. H0200 Scenario #2 Coding

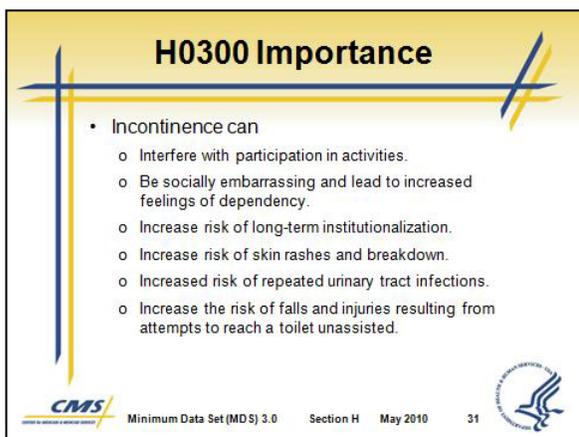
1. H0200A would be coded as **1. Yes.**
2. H0200B would be coded as **9. Unable to determine or trial in progress.**
3. H0200C would be coded as **1. Yes. (The toileting program is in progress.)**
4. Based on this resident's voiding assessment/diary, it was determined that this resident could benefit from a toileting program. Therefore H0200A is coded as **1. Yes.**
5. Based on the assessment it was determined that incontinence episodes could be reduced, therefore, H0200B is coded as **9. Unable to determine or trial in progress.**

**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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6. An individualized plan has been developed, implemented, and communicated to the resident and staff; therefore, H0200C is coded as **1**. Current toileting program or trial.

**IV. Item H0300 Urinary Incontinence**

- A. This item documents a resident's urinary incontinence status.

B. H0300 Importance

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

SLIDES		INSTRUCTIONAL GUIDANCE	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Urinary Incontinence</b></p> <p>The involuntary loss of urine</p>		<b>Notes</b>
		<b>Instructor Notes</b>	
		<b>Instructor Notes</b>	
<b>Notes</b>	<p><b>Urinary Continenence</b></p> <p>Any void into a commode, urinal, or bedpan that occurs voluntarily or as the result of prompted toileting, assisted toileting, or scheduled toileting.</p>		<b>Notes</b>
		<b>Instructor Notes</b>	

**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.

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### C. H0300 Conduct the Assessment

1. Review the medical record.
  - a. Bladder or incontinence records or flow sheets
  - b. Nursing assessments and progress notes
  - c. Physician history
  - d. Physical examination
2. Interview the resident if he or she is capable of reliably reporting his or her continence.
3. Speak with family members or significant others if resident is not able to report on continence.
4. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

**SLIDES**

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**INSTRUCTIONAL GUIDANCE**

D. H0300 Assessment Guidelines

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

E. H0300 Coding Instructions

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

- **Code 0. Always continent**  
If throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence

- **Code 1. Occasionally incontinent**  
If during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs or pads daytime or nighttime.

- **Code 2. Frequently incontinent**  
If during the 7-day look-back period, the resident was incontinent of urine 7 or more episodes, but had at least one continent void. This includes incontinence of any amount of urine, daytime and nighttime.

## SLIDES

## INSTRUCTIONAL GUIDANCE

- **Code 3. Always incontinent**  
If during the 7-day look-back period, the resident had no continent voids
- **Code 9. Not rated**  
If during the 7-day look-back period the resident had an indwelling bladder catheter, condom catheter, ostomy, or no urine output (e.g. is on chronic dialysis with no urine output) for the entire 7 days

**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.

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## F. H0300 Scenario

1. An 86-year-old female resident has had longstanding stress-type incontinence for many years.
2. When she has an upper respiratory infection and is coughing, she involuntarily loses urine.
3. 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.
4. H0300 Scenario Coding
  - a. H0300 would be coded **0**. Always continent.
  - b. Even though the resident has known intermittent stress incontinence, she was continent during the current 7-day look-back period.

**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 - Select the one category that best describes the resident  
 0. Always continent  
 1. Occasionally incontinent (less than 7 episodes of incontinence)  
 2. Frequently incontinent (7 or more episodes of incontinence, but at least one episode of continent voiding)  
 3. Always incontinent (no continent voiding, urinary ostomy, or no urine output for the entire 7 days)  
 9. Not rated, resident had a urinary catheter, condom catheter, or no urine output for the entire 7 days

Enter Code: **0**

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**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**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.


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G. H0300 Practice #1

1. A resident with multi-infarct dementia:
  - a. Is incontinent of urine on three occasions on day one of observation
  - b. Is continent of urine in response to toileting on days two and three
  - c. 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


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H. How should H0300 be coded?

*Give participants time to answer the question.*

1. Correct answer is C. Code **2**. Frequently incontinent

**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.


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I. H0300 Practice #1 Coding

1. The correct code is **2**. Frequently incontinent.
2. The resident had seven documented episodes of urinary incontinence over the look-back period.
3. 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.

## SLIDES

### 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.

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### How should H0300 be coded?

- Code 0. Always continent
- Code 1. Occasionally incontinent
- Code 2. Frequently incontinent
- Code 3. Always incontinent
- Code 9. Not rated

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### 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.

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## INSTRUCTIONAL GUIDANCE

## J. H0300 Practice #2

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

## K. How should H0300 be coded?

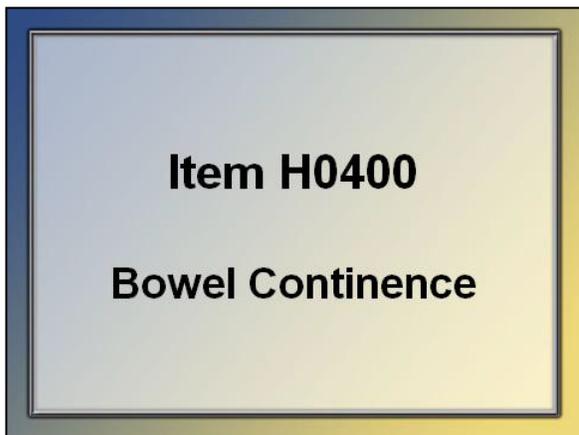
*Give participants time to answer the question.*

1. Correct answer is D. Code **3**. Always incontinent.

## 2. H0300 Practice #2 Coding

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

**SLIDES**

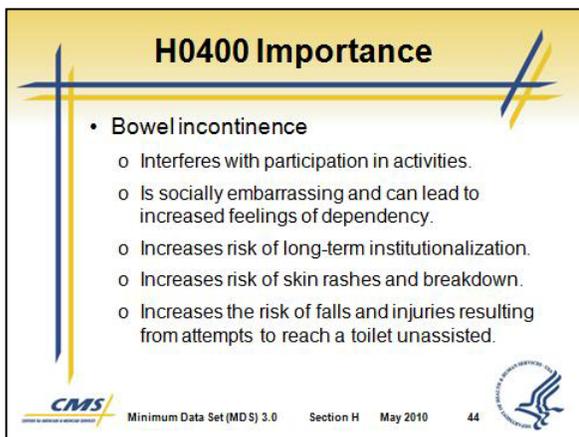


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**INSTRUCTIONAL GUIDANCE**

**V. H0400 Bowel Continence**

A. This item documents a resident's bowel continence status.



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B. H0400 Importance

1. Bowel incontinence leads to many of the same risks as urinary incontinence:
  - a. Interferes with participation in activities
  - b. Is socially embarrassing and can lead to increased feelings of dependency
  - c. Increases risk of long-term institutionalization
  - d. Increases risk of skin rashes and breakdown
  - e. Increases the risk of falls and injuries resulting from attempts to reach a toilet unassisted

## SLIDES

**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.

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**H0400 Assessment Guidelines**

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

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## INSTRUCTIONAL GUIDANCE

## C. H0400 Conduct the Assessment

1. Review the medical record.
  - a. Bowel records and incontinence flow sheets
  - b. Nursing assessments and progress notes
  - c. Physician history
  - d. Physical examination
2. Interview the resident if he or she is capable of reliably reporting his or her bowel habits.
3. Speak with family members or significant others if resident is unable to report on continence.
4. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

## D. H0400 Assessment Guidelines

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

## SLIDES

**H0400 Coding Instructions**

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

**H0400. Bowel Continence** - Select the one category that best describes the resident's bowel incontinence during the look-back period.

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

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## INSTRUCTIONAL GUIDANCE

## E. H0400 Coding Instructions

- Code according to the number of episodes of bowel incontinence that occur during the look-back period.
  - Code 0. Always continent**  
If throughout the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence
  - Code 1. Occasionally incontinent**  
If during the 7-day look-back period the resident was incontinent of stool once. This includes incontinence of any amount of stool day or night.
  - Code 2. Frequently incontinent**  
If during the 7-day look-back period, the resident was incontinent of bowel more than once but had at least one continent bowel movement. This includes incontinence of any amount of stool day or night.
  - Code 3. Always incontinent**  
If during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements

## SLIDES

## INSTRUCTIONAL GUIDANCE

- **Code 9. Not rated**

If during the 7-day look-back period the resident had an ostomy or did not have a bowel movement for the entire 7 days

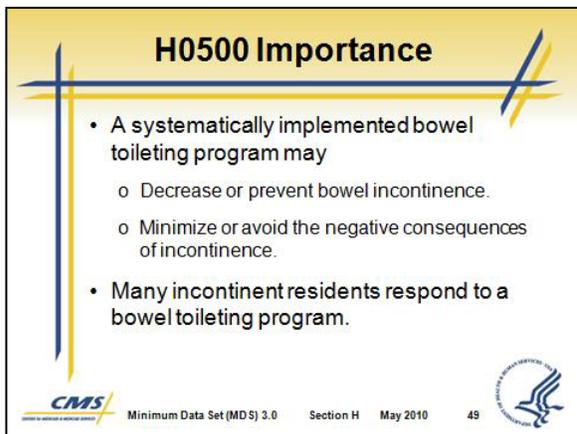
(Note that these residents should be checked for fecal impaction and evaluated for constipation.)



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## VI. H0500 Bowel Toileting Program

A. This item documents whether a toileting program is being used to manage a resident's bowel incontinence.



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B. H0500 Importance

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

**SLIDES**

**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

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**INSTRUCTIONAL GUIDANCE**

- C. H0500 Conduct the Assessment
1. Review the medical record for evidence of a bowel toileting program.
  2. Look for documentation of 3 requirements.
  3. These requirements are similar to those covered earlier for a urinary incontinence program):
    - a. Implementation of an individualized, resident-specific toileting program based on an assessment of the resident's unique bowel pattern
    - b. 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
    - c. 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?

0 No

1 Yes

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- D. H0500 Coding Instructions
1. Code according to whether a toileting program is used to manage bowel continence.
    - **Code 0. No**  
If the resident is not currently on a toileting program targeted specifically at managing bowel continence
    - **Code 1. Yes**  
If the resident is currently on a toileting program targeted specifically at managing bowel continence

**SLIDES**

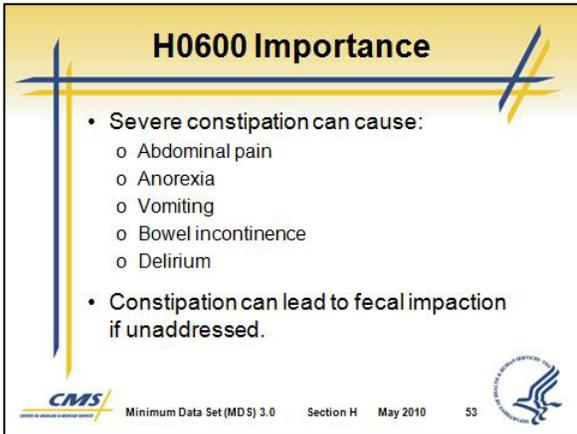
**INSTRUCTIONAL GUIDANCE**



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**VII. H0600 Bowel Patterns**

A. This item documents whether a resident has experienced any problems with constipation during the look-back period.



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B. H0600 Importance

1. Severe constipation can cause:
  - a. Abdominal pain
  - b. Anorexia
  - c. Vomiting
  - d. Bowel incontinence
  - e. Delirium
2. Constipation can lead to fecal impaction if unaddressed.
3. Fecal impaction is constipation.

**Instructor Notes**

**Constipation**

If the resident has two or fewer bowel movements during the 7-day look-back period or if for most bowel movements their stool is hard and difficult for them to pass (no matter what the frequency of bowel movements).

**Instructor Notes**

**Instructor Notes**

**Fecal Impaction**

A large mass of dry, hard stool that can develop in the rectum due to chronic constipation. This mass may be so hard that the resident is unable to move it from the rectum. Watery stool from higher in the bowel or irritation from the impaction may move around the mass and leak out, causing soiling, often a sign of a fecal impaction. Consider fecal impaction under constipation.

**Instructor Notes**

**SLIDES**

**INSTRUCTIONAL GUIDANCE**

**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.

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**H0600 Coding Instructions**

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

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

0 No  
1 Yes

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C. H0600 Conduct the Assessment

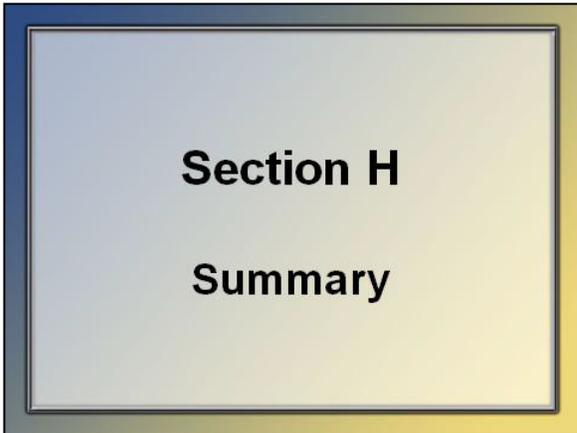
1. Review the medical record for evidence of constipation.
  - a. Bowel records or flow sheets
  - b. Nursing assessments and progress notes
  - c. Physician history
  - d. Physical examination
2. Interview the resident.
3. Speak with family members or significant others if resident is not able to report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

D. H0600 Coding Instructions

1. Code according to whether a resident shows signs of constipation during the look-back period.
  - **Code 0. No**  
If the resident shows no signs of constipation during the 7-day look-back period
  - **Code 1. Yes**  
If the resident show signs of constipation during the 7-day look-back period

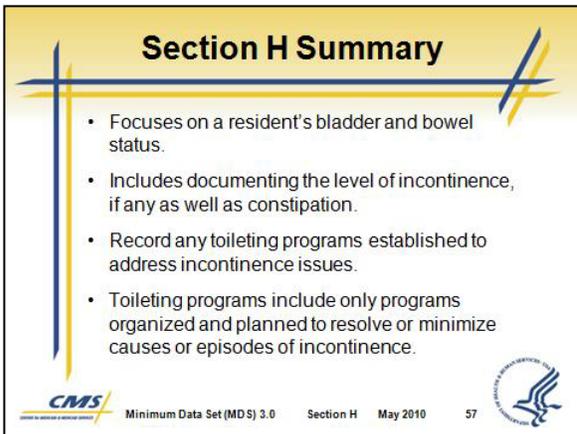
**SLIDES**

**INSTRUCTIONAL GUIDANCE**



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**VIII. Section H Summary**



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- A. Section H dealt with the resident's bladder and bowel status.
- B. This includes documenting a resident's level of incontinence, if any as well as constipation.
- C. Record any type of urinary or bowel toileting program to assist the resident with any incontinence issues.
- D. Toileting programs include only those programs that are organized and planned to resolve or minimize causes or episodes of incontinence.

