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 Importance$_1$

- 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 Importance$_2$

- 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	
☐	A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
☑	B. **External catheter**
☐	C. **Ostomy** (including urostomy, ileostomy, and colostomy)
☑	D. **Intermittent catheterization**
☐	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 Program[1]

- 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 Program$_2$

- 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 Assessment[1]

- 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 Assessment$_2$

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

H0200A Assessment Guidelines[1]

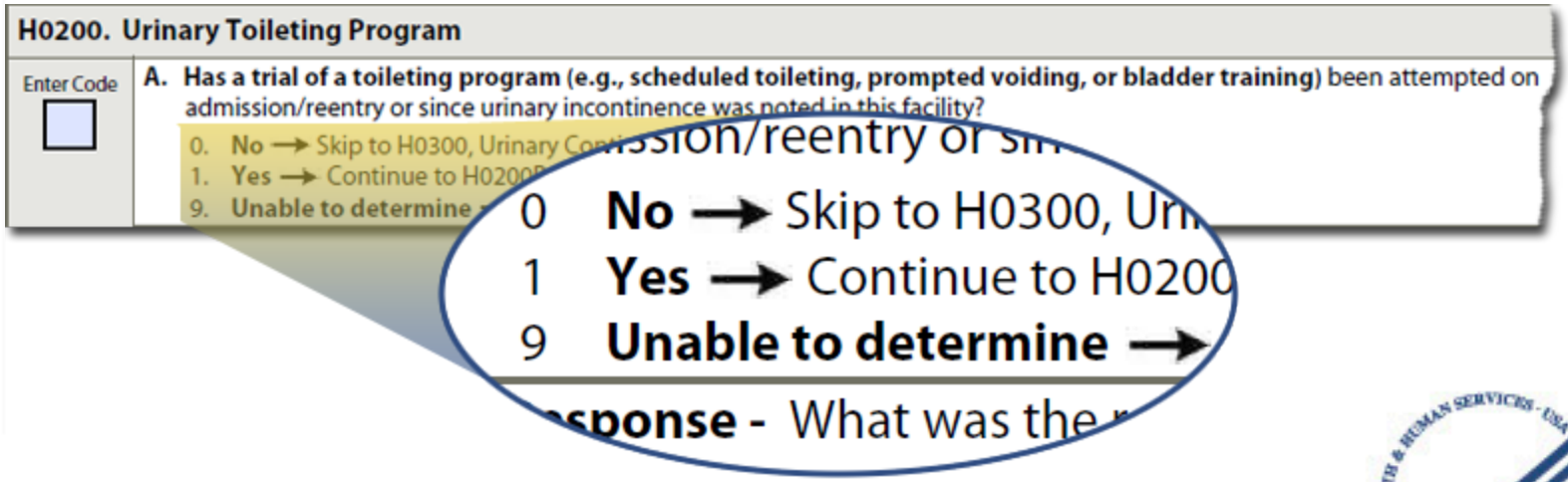
- Look-back period for H0200A:
  - Most recent admission/ readmission assessment
  - Most recent prior assessment
  - When incontinence was first noted
- Voiding records:
  - Help detect urinary patterns or intervals between incontinence episodes.
  - Facilitate providing care to avoid or reduce the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

H0200A Assessment Guidelines$_2$

- 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.

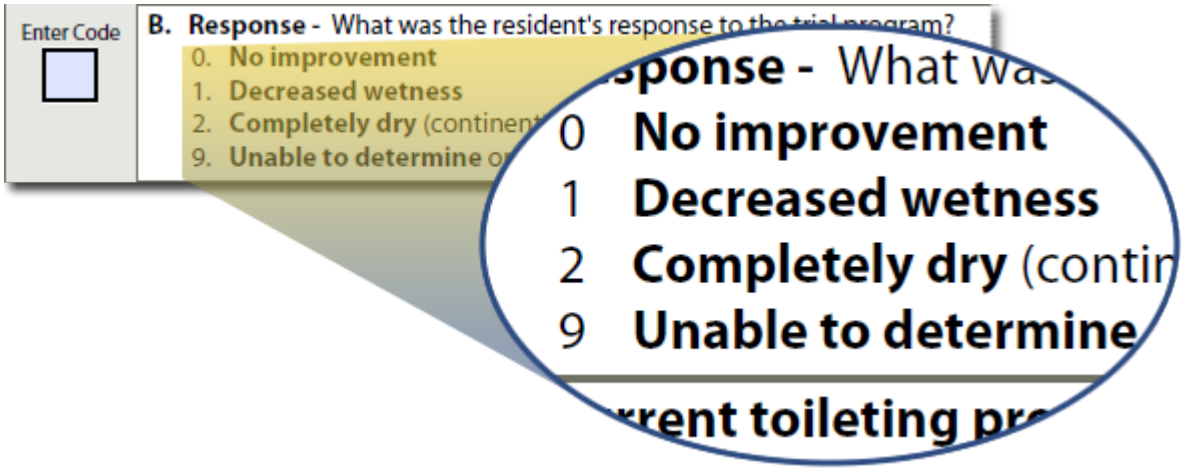


H0200B Toileting Program Trial Response Conduct the Assessment

- 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.



H0200C Current Toileting Program Conduct the Assessment[1]

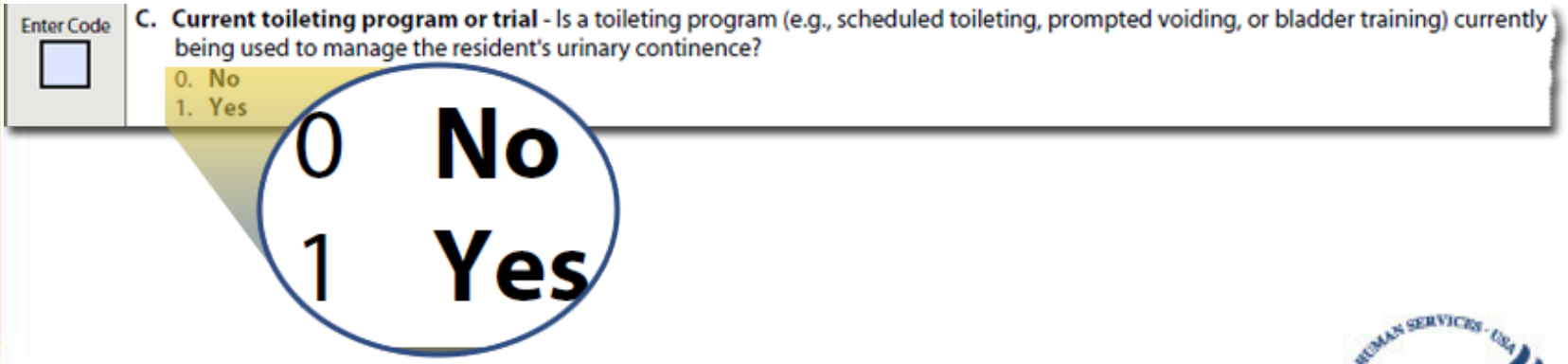
- The look-back period is **7 days**.
- Review the medical record for evidence of a toileting program being used to manage incontinence.
- Note the number of days that the toileting program was implemented or carried out during the look-back period.

H0200C Current Toileting Program Conduct the Assessment$_2$

- 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.



Coding a Trial in Progress

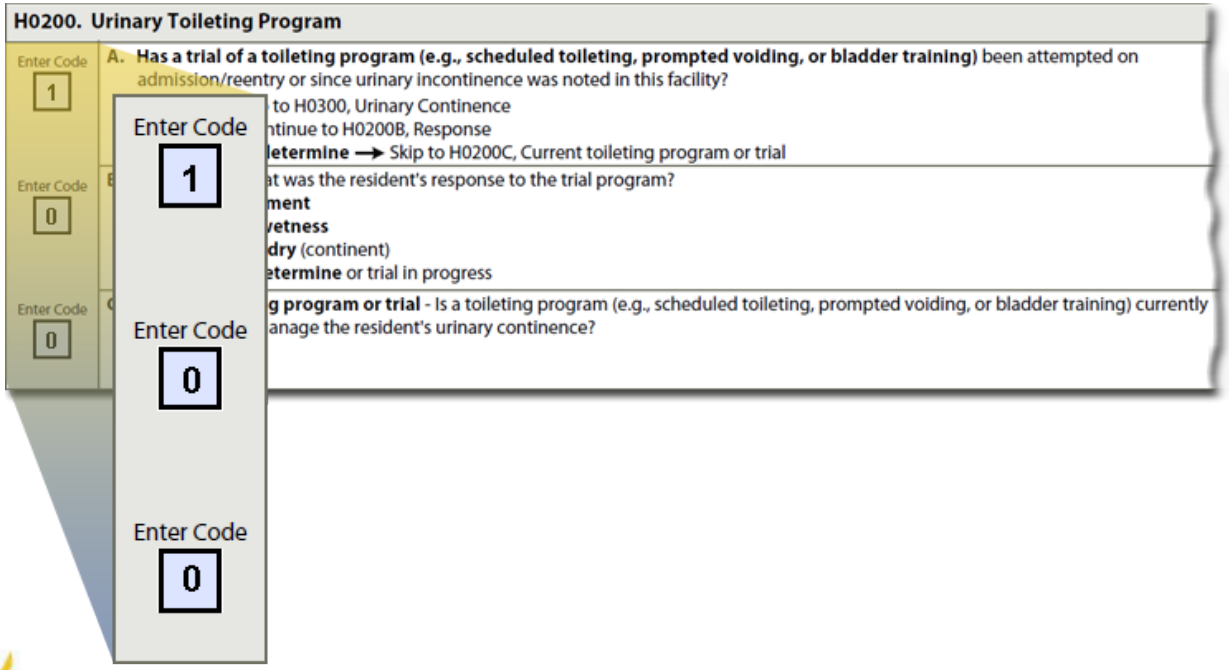
- If a resident is currently undergoing a toileting program trial:
  - Code H0200A as **1. Yes**, a trial toileting program is attempted.
  - Code H0200B as **9.** Unable to determine or trial in progress.
  - Code H0200C as **1. Yes** for current toileting program.

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 Scenario #2$_1$

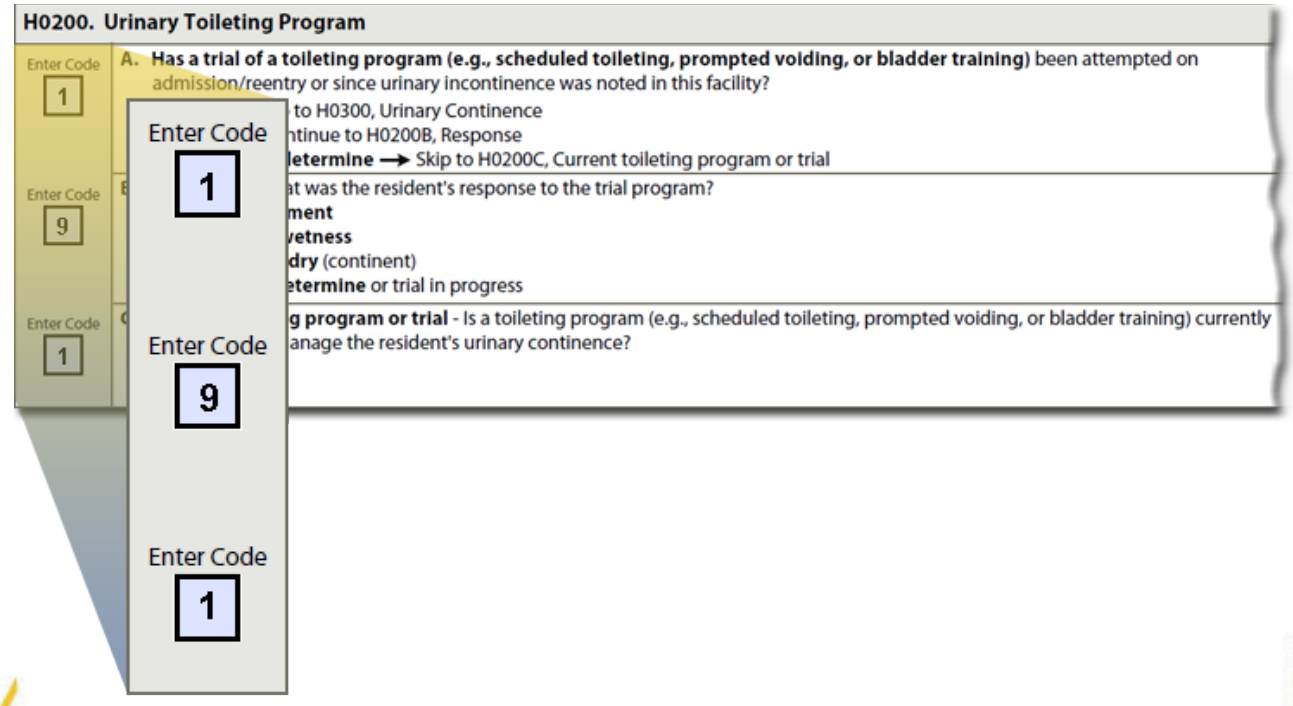
- Mr. M., who has a diagnosis of congestive heart failure (CHF) and a history of left-sided hemiplegia from a previous stroke, has had an increase in urinary incontinence.
- The team has assessed him for a reversible cause of the incontinence and has evaluated his voiding pattern using a voiding assessment/ diary.
- After completing the assessment, it was determined that incontinence episodes could be reduced.

H0200 Scenario #2$_2$

- 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.



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

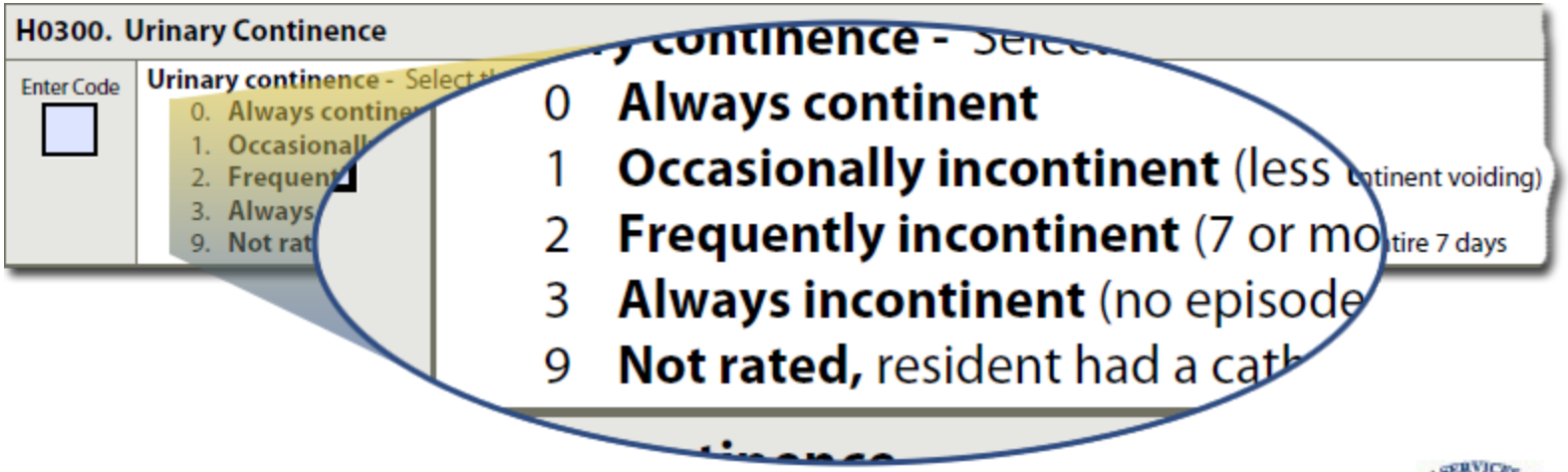
- Review the medical record.
  - Bladder or incontinence records or flow sheets
  - Nursing assessments and progress notes
  - Physician history
  - Physical examination
- Interview the resident (if capable of reporting).
- Speak with family members or significant others if resident is not able to report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

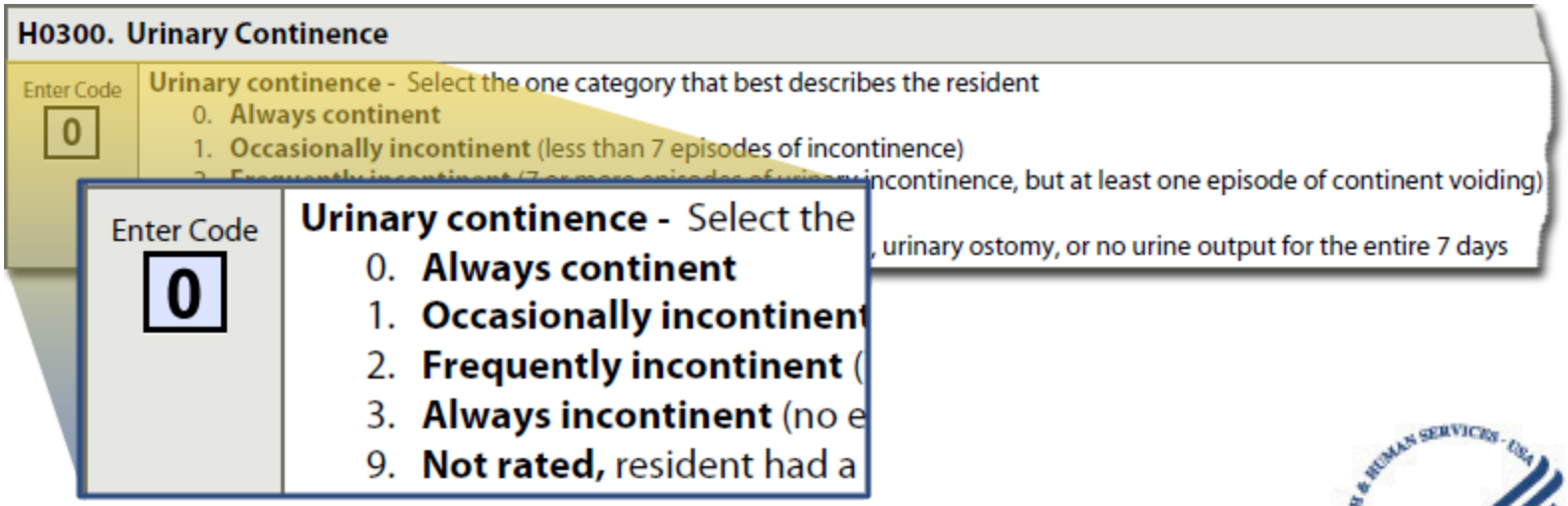


H0300 Scenario

- 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 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

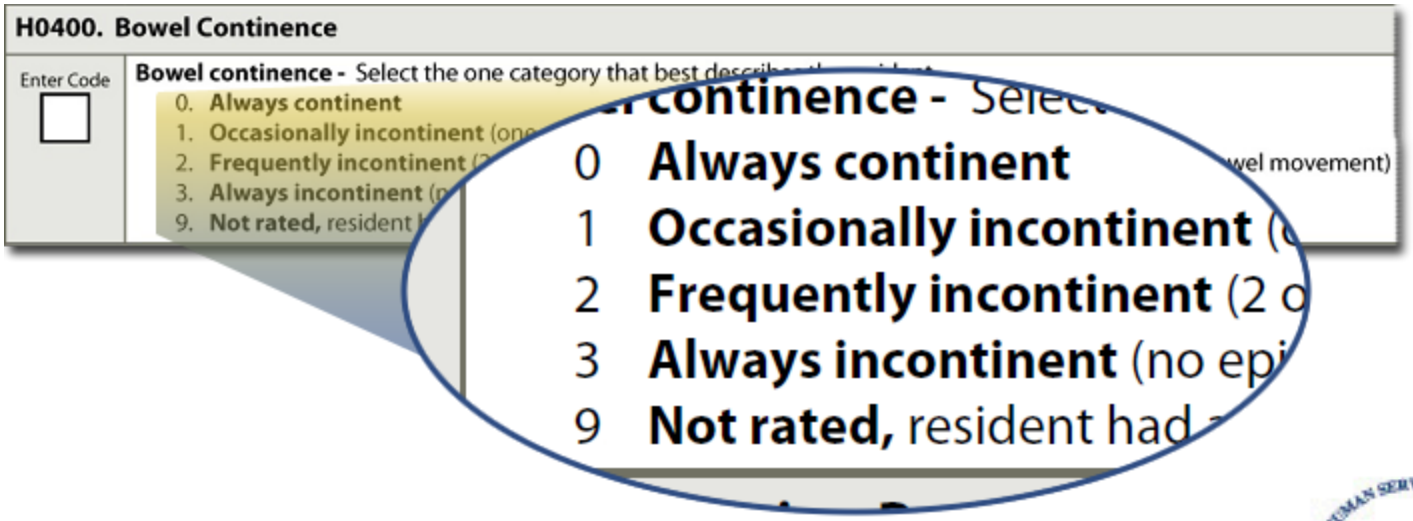
- Review the medical record.
  - Bowel records and incontinence flow sheets
  - Nursing assessments and progress notes
  - Physician history
  - Physical examination
- Interview the resident (if capable of reporting).
- Speak with family members or significant others if resident is not able to report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



Item H0500

Bowel Toileting Program

H0500 Importance

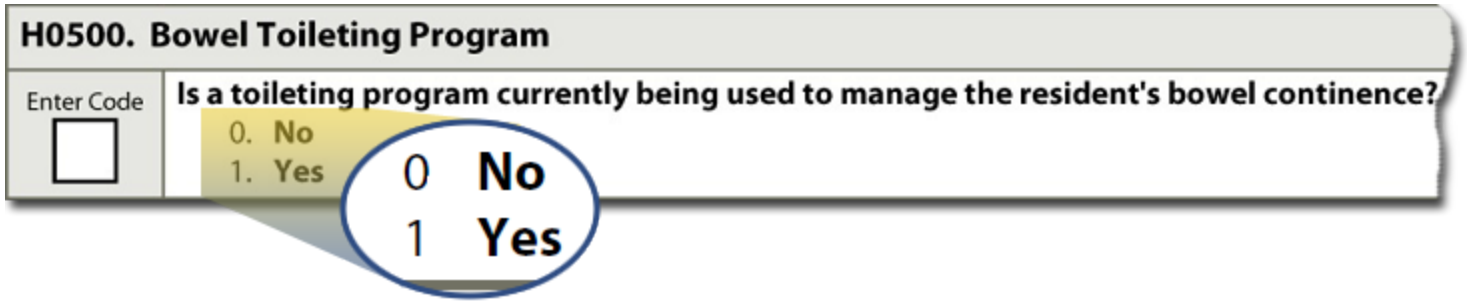
- A systematically implemented bowel toileting program may
  - Decrease or prevent bowel incontinence.
  - Minimize or avoid the negative consequences of incontinence.
- Many incontinent residents respond to a bowel toileting program.

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.



Item H0600

Bowel Patterns

H0600 Importance

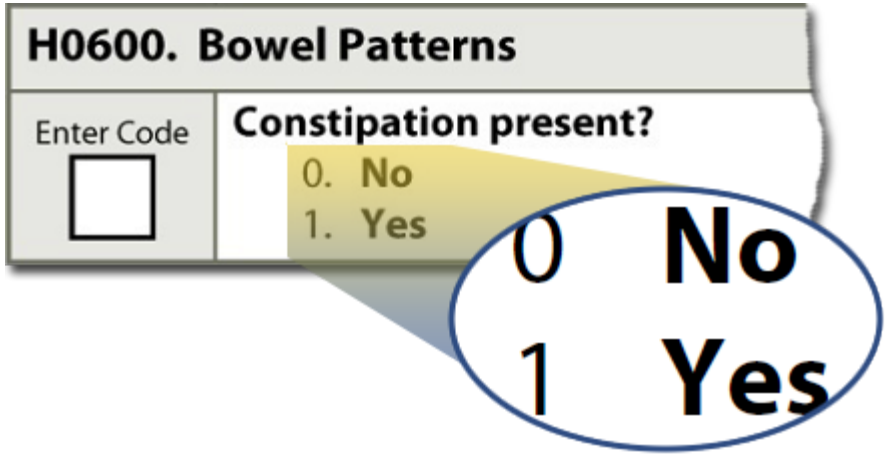
- Severe constipation can cause:
  - Abdominal pain
  - Anorexia
  - Vomiting
  - Bowel incontinence
  - Delirium
- Constipation can lead to fecal impaction if unaddressed.

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.



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.