

SECTION H: BLADDER AND BOWEL

Intent: For the July 1, 2014, release of the LTCH CARE Data Set, Version 2.01, one item (H0400: Bowel Continence) is included in this section. This item gathers information on bowel continence. If warranted by additional quality measures finalized by CMS for the LTCHQR Program through future rule-making cycles, CMS may add additional items to this section, such as bladder continence.

H0400: Bowel Continence

H0400. Bowel Continence (Complete during the 3-day assessment period.)	
Enter Code <input type="checkbox"/>	Bowel continence - Select the one category that best describes the patient. 0. Always continent 1. Occasionally incontinent (one episode of bowel incontinence) 2. Frequently incontinent (2 or more episodes of bowel incontinence, but at least one continent bowel movement) 3. Always incontinent (no episodes of continent bowel movements) 9. Not rated , patient had an ostomy or did not have a bowel movement for the entire 3 days

Item Rationale

- 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, and development and/or worsening of pressure ulcers; and
 - increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.
- For many patients, incontinence can be resolved or minimized by
 - identifying and managing underlying and potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with a new or recent onset of incontinence); and
 - eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

Steps for Assessment

1. Review the medical record for bowel incontinence flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the patient if he or she is capable of reliably reporting his or her bowel habits. Speak with family members or significant other if the patient is unable to report on continence.

3. Ask direct care staff from all shifts who routinely work with the patient about incontinence episodes.

Coding Instructions

Complete only if A0250 = 01.

- 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 of stool 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 of bowel at least twice, but also had at least one continent bowel movement. This includes incontinence of any amount 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 did not have a bowel movement for the entire 3 days. Note that these patients should be checked for fecal impaction and evaluated for constipation.

Coding Tips and Special Populations

- Being continent has to do with the ability to void voluntarily in a commode or urinal or as a result of prompting toileting, assisted toileting, or scheduling toileting.
- If the patient *cannot* voluntarily control the passage of stool, which results in involuntary passage of stool, then he or she is considered incontinent.
- Patients who require assistance to maintain the passage of stool via artificial initiation (e.g., manual stimulation, rectal suppositories, or enema) would be considered *continent* of bowel.
- Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.
- This item is strictly limited to capturing information on patient's bowel continence *without the use of a fecal management system or rectal tube*. A dash ('-') would be the appropriate code when these devices are in use, unless there is a way to assess the patient's bowel continence without these devices in place.