H0400: Bowel Continence

H0400.	Bowel Continence
Enter Code ☐	**Bowel continence** - Select the one category that best describes the resident **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,** resident had an ostomy or did not have a bowel movement for the entire 7 days

Item Rationale

Health-related Quality of Life

- 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
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and managing underlying potentially reversible causes, including medication side effects, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence); and
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals.

H0400: Bowel Continence (cont.)

- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to stool.

Steps for Assessment

1. Review the medical record for bowel records and incontinence flow sheets, nursing assessments and progress notes, physician history and physical examination.
2. Interview the resident if they are capable of reliably reporting their bowel habits. Speak with family members or significant other if the resident is unable to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Coding Instructions

- **Code 0, always continent:** if during 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.
- **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.)

Coding Tips and Special Populations

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