SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns. 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.

H0100: Appliances

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 Rationale

Health-related Quality of Life

- It is important to know what appliances are in use and the history and rationale for such use.
- External catheters should fit well and be comfortable, minimize leakage, maintain skin integrity, and promote resident dignity.
- Indwelling catheters should not be used unless there is valid medical justification. Assessment should include consideration of the risk and benefits of an indwelling catheter, the anticipated duration of use, and consideration of complications resulting from the use of an indwelling catheter. Complications can include an increased risk of urinary tract infection, blockage of the catheter with associated bypassing of urine, expulsion of the catheter, pain, discomfort, and bleeding.
- Ostomies (and peristomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.

Planning for Care

- Care planning should include interventions that are consistent with the resident's goals and minimize complications associated with appliance use.

DEFINITIONS

INDWELLING CATHETER
A catheter that is maintained within the bladder for the purpose of continuous drainage of urine.

SUPRAPUBIC CATHETER
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.

NEPHROSTOMY TUBE
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.

Draft

H0100: Appliances (cont.)

- Care planning should be based on an assessment and evaluation of the resident's history, physical examination, physician orders, progress notes, nurses' notes and flow sheets, pharmacy and lab reports, voiding history, resident's overall condition, risk factors and information about the resident's continence status, catheter status, environmental factors related to continence programs, and the resident's response to catheter/continence services.

Steps for Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.
2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

*Check next to each appliance that was used at any time in the past 7 days. 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

Coding Tips and Special Populations

- Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
- Condom catheters and external urinary pouches are often used intermittently or at night only; these should be coded as external catheters.
- Do not code gastrostomies or other feeding ostomies in this section. Only appliances used for elimination are coded here.
- Do not include one-time catheterizations for urine specimen *collection or other diagnostic exams (e.g., to measure post-void residual)* during look-back period as intermittent catheterization.

DEFINITIONS

EXTERNAL CATHETER
Device attached to the shaft of the penis like a condom or a receptacle pouch that fits around the labia majora and connected to a drainage bag.

OSTOMY
Any type of surgically created opening of the gastrointestinal or genitourinary tract for discharge of body waste.

UROSTOMY
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.

ILEOSTOMY
A stoma that has been constructed by bringing the end or loop of small intestine (the ileum) out onto the surface of the skin.

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

INTERMITTENT CATHETERIZATION
Insertion and removal of a catheter through the urethra for bladder drainage.

Draft

H0100: Appliances (cont.)

- Self-catheterizations that are performed by the resident in the facility should be coded as intermittent catheterization (H0100D). This includes self-catheterizations using clean technique.

H0200: Urinary Toileting Program

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/entry or reentry or since urinary incontinence was noted in this facility? 0. **No** → Skip to H0300, Urinary Continence 1. **Yes** → Continue to H0200B, Response 9. **Unable to determine** → Skip to H0200C, Current toileting program or trial
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
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**

Item Rationale

Health-related Quality of Life

- An individualized, resident-centered toileting program may decrease or prevent urinary incontinence, minimizing or avoiding the negative consequences of incontinence.
- Determining the type of urinary incontinence can allow staff to provide more individualized programming or interventions to enhance the resident's quality of life and functional status.
- Many incontinent residents (including those with dementia) respond to a toileting program, especially during the day.

Planning for Care

- The steps toward ensuring that the resident receives appropriate treatment and services to restore as much bladder function as possible are
  - determining if the resident is currently experiencing some level of incontinence or is at risk of developing urinary incontinence;
  - completing an accurate, thorough assessment of factors that may predispose the resident to having urinary incontinence; and
  - implementing appropriate, individualized interventions and modifying them as appropriate.
- If the toileting program or bladder retraining leads to a decrease or resolution of incontinence, the program should be maintained.
- Research has shown that one quarter to one third of residents will have a decrease or resolution of incontinence in response to a toileting program.
- If incontinence is not decreased or resolved with a toileting trial, consider whether other reversible or treatable causes are present.

Draft

H0200: Urinary Toileting Program (cont.)

- Residents may need to be referred to practitioners who specialize in diagnosing and treating conditions that affect bladder function.
- Residents who do not respond to a toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as checking the resident for incontinence and changing *their* brief if needed and providing good skin care).

Steps for Assessment: H0200A, Trial of a Toileting Program

The look-back period for this item is since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.

1. Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observations of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary. Toileting programs may have different names, e.g., habit training/scheduled voiding, bladder rehabilitation/bladder retraining.
2. Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence.
3. Voiding records help detect urinary patterns or intervals between incontinence episodes and facilitate providing care to avoid or reduce the frequency of episodes.
4. Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program.
5. Residents should be reevaluated whenever there is a change in cognition, physical ability, or urinary tract function. Nursing home staff must use clinical judgment to determine when it is appropriate to reevaluate a resident's ability to participate in a toileting trial or, if the toileting trial was unsuccessful, the need for a trial of a different toileting program.

DEFINITIONS

BLADDER REHABILITATION/ BLADDER RETRAINING
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.

PROMPTED VOIDING
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.

HABIT TRAINING/ SCHEDULED VOIDING
A behavior technique that calls for scheduled toileting at regular intervals on a planned basis to match the resident's voiding habits or needs.

CHECK AND CHANGE
Involves checking the resident's dry/wet status at regular intervals and using incontinence devices and products.

H0200: Urinary Toileting Program (cont.)

Steps for Assessment: H0200B, Response to Trial Toileting Program

1. Review the resident's responses as recorded during the toileting trial, noting any change in the number of incontinence episodes or degree of wetness the resident experiences.

Steps for Assessment: H0200C, Current Toileting Program or Trial

1. Review the medical record for evidence of a toileting program being used to manage incontinence during the 7-day look-back period. Note the number of days during the look-back period that the toileting program was implemented or carried out.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific toileting program that was 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; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.
3. Guidance for developing a toileting program may be obtained from sources found in Appendix C.

Coding Instructions H0200A, Toileting Program Trial

- **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).
- **Code 1, yes:** for residents who underwent a trial of an individualized, resident-centered toileting program at least once since the most recent admission/entry or reentry or since urinary incontinence was first noted within the facility.
- **Code 9, unable to determine:** if records cannot be obtained to determine if a trial toileting program has been attempted. If code 9, skip H0200B and go to H0200C, **Current Toileting Program or Trial**.

Coding Instructions H0200B, Toileting Program Trial Response

- **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. 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.

DRAFT

H0200: Urinary Toileting Program (cont.)

- **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 the trial is still in progress.

Coding Instructions H0200C, Current Toileting Program

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

Coding Tips for H0200A-C

- Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated that is consistent with the nursing home's policies and procedures and current standards of practice. A toileting program does not refer to
  - simply tracking continence status,
  - changing pads or wet garments, and
  - random assistance with toileting or hygiene.
- For a resident currently undergoing a trial of a toileting program,
  - H0200A would be **coded 1, yes,**
  - H0200B would be **coded 9, unable to determine or trial in progress**, and
  - H0200C would be **coded 1, yes.**

Draft

H0200: Urinary Toileting Program (cont.)

Examples

1. *Resident* H has a diagnosis of advanced Alzheimer's disease. *They are* dependent on the staff for *their* ADLs, do not have the cognitive ability to void in the toilet or other appropriate receptacle, and *are* totally incontinent. *Their* voiding assessment/diary indicates no pattern to *their* incontinence. *Their* care plan states that due to *their* total incontinence, staff should follow the facility standard policy for incontinence, which is to check and change every 2 hours while awake and apply a superabsorbent brief at bedtime so as not to disturb *their* sleep.

   Coding: H0200A would be **coded as 0, no**. H0200B and H0200C would be skipped.

   Rationale: Based on this resident's voiding assessment/diary, there was no pattern to *their* incontinence. Therefore, H0200A would be coded as 0, no. Due to total incontinence a toileting program is not appropriate for this resident. Since H0200A is coded 0, no, skip to H0300, Urinary Continence.

2. *Resident* 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 *them* for a reversible cause of the incontinence and has evaluated *their* voiding pattern using a voiding assessment/diary. After completing the assessment, it was determined that incontinence episodes could be reduced. A plan was developed and implemented that called for toileting every hour for 4 hours after receiving *their* 8 a.m. diuretic, then every 3 hours until bedtime at 9 p.m. The team has communicated this approach to the resident and the care team and 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.

   Coding: H0200A would be **coded as 1, yes.**

   H0200B would be **coded as 9, unable to determine or trial in progress.**

   H0200C would be **coded as 1, current toileting program or trial.**

   Rationale: 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. 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. 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.

Draft

H0300: Urinary Continence

H0300. Urinary Continence	
Enter Code ☐	**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 urinary incontinence, but at least one episode of continent voiding) 3. **Always incontinent** (no episodes of continent voiding) 9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output 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,
  - — increase risk of repeated urinary tract infections, and
  - — increase the risk of falls and injuries resulting from attempts to reach a toilet unassisted.

DEFINITIONS

URINARY INCONTINENCE
The involuntary loss of urine.

CONTINENCE
Any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting.

Planning for Care

- For many residents, incontinence can be resolved or minimized by
  - — identifying and treating underlying potentially reversible causes, including medication side effects, urinary tract infection, constipation and fecal impaction, and immobility (especially among those with the new or recent onset of incontinence);
  - — eliminating environmental physical barriers to accessing commodes, bedpans, and urinals; and
  - — bladder retraining, prompted voiding, or scheduled toileting.
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining, prompted voiding, or scheduled toileting, the interdisciplinary team should establish a plan to maintain skin dryness and minimize exposure to urine.

Steps for Assessment

1. Review the medical record for bladder or incontinence records or flow sheets, nursing assessments and progress notes, physician history, and physical examination.
2. Interview the resident if *they are* capable of reliably reporting *their* continence. Speak with family members or significant others if the resident is not able to report on continence.
3. Ask direct care staff who routinely work with the resident on all shifts about incontinence episodes.

Draft

H0300: Urinary Continence (cont.)

Coding Instructions

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

Coding Tips and Special Populations

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

Examples

1. An 86-year-old resident has had longstanding stress-type incontinence for many years. When *they have* an upper respiratory infection and *are* coughing, *they* involuntarily lose 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.

   Coding: H0300 would be **coded 0, always continent**.
   Rationale: Even though the resident has known intermittent stress incontinence, *they were* continent during the current 7-day look-back period.

> ***DEFINITION***
>
> ***STRESS INCONTINENCE***
> *Episodes of a small amount of urine leakage only associated with physical movement or activity such as coughing, sneezing, laughing, lifting heavy objects, or exercise.*

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

   Coding: H0300 would be **coded as 2, frequently incontinent.**
   Rationale: The resident had seven documented episodes of urinary incontinence *during* 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.

Draft

H0300: Urinary Continence (cont.)

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

   Coding: H0300 would be **coded as 3, always incontinent.**

   Rationale: 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" protocol.

4. A resident had one continent urinary void during the 7-day look-back period, after the nursing assistant assisted *them* to the toilet and helped with clothing. All other voids were incontinent.

   Coding: H0300 would be **coded as 2, frequently incontinent.**

   Rationale: The resident had at least one continent void during the look-back period. The reason for the continence does not enter into the coding decision.

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.

Draft

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.

Draft

H0500: Bowel Toileting Program

H0500. Bowel Toileting Program	
Enter Code ☐	Is a toileting program currently being used to manage the resident's bowel continence? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- A systematically implemented bowel toileting program may decrease or prevent bowel incontinence, minimizing or avoiding the negative consequences *associated with* incontinence.
- Many incontinent residents respond to a bowel toileting program, especially during the day.

Planning for Care

- If the bowel toileting program leads to a decrease or resolution of incontinence, the program should be maintained.
- If bowel incontinence is not decreased or resolved with a bowel toileting trial, consider whether other reversible or treatable causes are present.
- Residents who do not respond to a bowel toileting trial and for whom other reversible or treatable causes are not found should receive supportive management (such as a regular check and change program with good skin care).
- Residents with a colostomy or colectomy may need their diet monitored to promote healthy bowel elimination and careful monitoring of skin to prevent skin irritation and breakdown.
- When developing a toileting program the provider may want to consider assessing the resident for adequate fluid intake, adequate fiber in the diet, exercise, and scheduled times to attempt bowel movement (Newman, 2009).

Steps for Assessment

1. Review the medical record for evidence of a bowel toileting program being used to manage bowel incontinence during the 7-day look-back period.
2. Look for documentation in the medical record showing that the following three requirements have been met:
   - implementation of an individualized, resident-specific bowel 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, verbal and a written report; and
   - notations of the resident's response to the toileting program and subsequent evaluations, as needed.

Draft

H0500: Bowel Toileting Program (cont.)

Coding Instructions

- **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.

H0600: Bowel Patterns

H0600. Bowel Patterns	
Enter Code ☐	Constipation present? 0. No 1. Yes

Item Rationale

Health-related Quality of Life

- Severe constipation can cause abdominal pain, anorexia, vomiting, bowel incontinence, and delirium.
- If unaddressed, constipation can lead to fecal impaction.

Planning for Care

- This item identifies residents who may need further evaluation of and intervention on bowel habits.
- Constipation may be a manifestation of serious conditions such as
  - dehydration due to a medical condition or inadequate access to and intake of fluid, and
  - side effects of medications.

DEFINITION

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).

Steps for Assessment

1. Review the medical record for bowel records or flow sheets, nursing assessments and progress notes, physician history and physical examination to determine if the resident has had problems with constipation during the 7-day look-back period.
2. Residents who are capable of reliably reporting their continence and bowel habits should be interviewed. Speak with family members or significant others if the resident is unable to report on bowel habits.
3. Ask direct care staff who routinely work with the resident on all shifts about problems with constipation.

DEFINITION

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.

Draft

H0600: Bowel Patterns (cont.)

Coding Instructions

- **Code 0, no:** if the resident shows no signs of constipation during the look-back period.
- **Code 1, yes:** if the resident shows signs of constipation during the look-back period.

Coding Tips and Special Populations

- Fecal impaction is caused by chronic constipation. Fecal impaction is not synonymous with constipation.

Draft