



Quality Measure Tip Sheet: Bowel and Bladder Incontinence—Long Stay

This measure was previously approved or given time limited endorsement by the National Quality Forum (NQF) but has been withdrawn from NQF submission.

Quality Measure Overview

- Reports the percentage of low risk residents who lose control of their bowel or bladder in a **7-day look-back period**.
- Resident will trigger this measure if the most recent Minimum Data Set (MDS) H0300/H0400 is coded as **frequently or always incontinent**.

Exclusions:

- Target assessment is admission, Medicare Prospective Payment System 5-day assessment, or Medicare readmission/return assessment.
- Resident has **high-risk conditions** such as severe cognitive impairment or total dependence in bed mobility, transfers, and locomotion.
- Resident **does not qualify as high risk** (see above) and both of the following two conditions are true: C0500 and C0700/C1000 coded as [99], [^], or [-].
- Resident does not qualify as high risk and any of the following three conditions are true: G0110A1, G0110B1, G0110E1 coded as [-].
- Resident is comatose or comatose status is missing.
- Resident has an indwelling catheter or status is missing.
- Resident has an ostomy or status is missing.
- Resident is not in the numerator and H300 or H400 is coded as [-].

MDS Coding Requirements *Refer to Section H*

In the MDS:

- Include a look-back period of seven days.
- Select H0300 (urinary continence) if the resident is always continent, occasionally incontinent, frequently incontinent, always incontinent, not rated due to indwelling catheter, condom, or urinary ostomy, or has had no urine output for entire seven days. **Tip:** If intermittent catheterization is used to drain the bladder, code continence level based on continence between catheterizations.
- Select H0400 (bowel continence) if the resident is always continent, occasionally incontinent, frequently incontinent, always incontinent, not rated due to ostomy or has had no bowel movement for entire seven days. **Tip:** Bowel incontinence precipitated by loose stools or diarrhea from any cause (including laxatives) would count as incontinence.

Consider These Questions ...

- Was the MDS coded per Resident Assessment Instrument (RAI) requirements?
- Is the staff member's coding documentation accurate?
- Are underlying conditions reviewed and treated for potential causative factors for incontinence (e.g., diabetes, kidney dysfunction, hypertension, medication adverse side effects, etc.)?
- Was the resident evaluated for elimination patterns for at least three days and were toilet programs developed to address individualized patterns?
- Was the resident re-evaluated for elimination patterns whenever there was a change in cognition, physical ability, or urinary tract function?
- Is continence managed through a check-and-change program if the resident is not appropriate for a toilet program?
- Is there documentation to support the:
 - Implementation of an individualized, resident-specific toilet program based on an assessment of the resident's unique voiding pattern?
 - Communication of the individualized program to staff members and resident through a care plan, flow records, and a written report?
 - Resident's response to the program and subsequent evaluations?
- For residents whose incontinence does not have a reversible cause and who do not respond to retraining programs, the interdisciplinary team (IDT) should establish a plan to maintain skin dryness and minimize exposure to stool and urine.

For guidance on your quality measures, reach out to Health Services Advisory Group (HSAG).

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