

OASIS ITEM
<p>(M1620) Bowel Incontinence Frequency:</p> <ul style="list-style-type: none"> <input type="checkbox"/> 0 - Very rarely or never has bowel incontinence <input type="checkbox"/> 1 - Less than once weekly <input type="checkbox"/> 2 - One to three times weekly <input type="checkbox"/> 3 - Four to six times weekly <input type="checkbox"/> 4 - On a daily basis <input type="checkbox"/> 5 - More often than once daily <input type="checkbox"/> NA - Patient has ostomy for bowel elimination <input type="checkbox"/> UK - Unknown
ITEM INTENT
<p>Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does <u>not</u> address treatment of incontinence or constipation (e.g., a bowel program).</p>
TIME POINTS ITEM(S) COMPLETED
<p>Start of care</p> <p>Resumption of care</p> <p>Follow-up</p> <p>Discharge from agency - not to inpatient facility</p>
RESPONSE—SPECIFIC INSTRUCTIONS
<ul style="list-style-type: none"> • Responses are arranged in order of least to most frequency of bowel incontinence. • Response 4 – On a daily basis – indicates that the patient experiences bowel incontinence once per day. • Response NA is used if patient has an ostomy for bowel elimination. • Unknown is not an option at follow-up or discharge. • Assessment strategies: Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient's responses to these items may make you aware of an as yet unidentified problem that needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.
DATA SOURCES / RESOURCES
<ul style="list-style-type: none"> • Patient/caregiver interview • Observation • Physical assessment • Review of health history • Referral information