Outline of steps for carrying out a baseline bowel assessment (level 1)

This reference sheet should be used in conjunction with the national community operations guideline for assessment, promotion and management of continence in adults by registered nurses 2019

STEP 1: For adults presenting with bowel dysfunction the RN completes bowel part of bladder & bowel assessment form. Obtain consent for data collection from client to have the assessment shared with other members of the MDT. Ensure privacy for patient during assessment.

During assessment consider factors at A,B,C below:

A-Medical details
Medical, surgical and obstetric history
Medications
Allergies
Cognitive status

B-Predisposing factors:
Urinary incontinence, faecal incontinence, loose stool, constipation,
Pelvic prolapse, anal surgery, Pelvic radiotherapy, peri-natal injuries/episiotomy, perianal itch
Neurological disease or injury
Inflammatory bowel diseases
Frail, learning disability.

C- Diet & lifestyle
Balanced diet and any existing therapeutic diets
Identify malnutrition using validated screening tool
Fluid intake
Toilet access
Correct positioning on toilet

TIP: malnutrition resources available at www.hse.ie/nutritionsupports

Presenting bowel problem

Allow client to describe symptoms in their own words. Where the person is unable to provide details due to a cognitive impairment or intellectual disability, the carer/HCP caring for them may provide details of symptoms and history. Discuss symptoms and how it impacts their daily life.

TIP: Bladder& bowel assessment form available at www.hse.ie/continencecare

STEP 2: Bowel assessment. Client, carer completes bladder & bowel record chart for 72 hours. Use Bristol stool chart to record type/ consistency/amount of stool. The symptoms should identify the possible cause of bowel dysfunction. There may be more than one cause.

Red flag signs & symptoms: altered bowel habit, blood in stool, abdominal pain, unexplained weight loss, rectal pain or bleeding, severe persistent constipation, family history.
Refer immediately to medical practitioner for physical examination/ investigations.

STEP 3 : Instigate following management if client presents with diarrhoea, constipation, faecal impaction.

Constipation
Assess diet, fluid, exercise for predisposing factors- introduce changes if required

Advise on correcting position
Provide health education ie information sheets

Hard stool(Bristol 1-3) – oral laxative (faecal softener) prescribed by Medical Practitioner /ANP
Soft stool(Bristol 5-7) – oral laxative (faecal stimulant) as prescribed by Medical Practitioner/ANP

Reassess stool consistency and review care-plan accordingly
GP referral /medication review

Diarrhoea
Sudden onset e.g **infection (refer to IPC precautions)**, recent travel, food poisoning- observe vital signs & refer as to medical practitioner. Refer for stool sample.
Overflow associated with constipation/ impaction
Pre-existing medical/surgical conditions
Trigger foods
Overuse of laxatives or medication induced- offer education & advice on appropriate laxatives and diet

- Encourage adequate fluid intake
- Skincare advice
- Facilitate access to toilet
- Continue to monitor and assess client until symptoms have resolved
- Refer to medical practitioner if symptoms persist /medication review

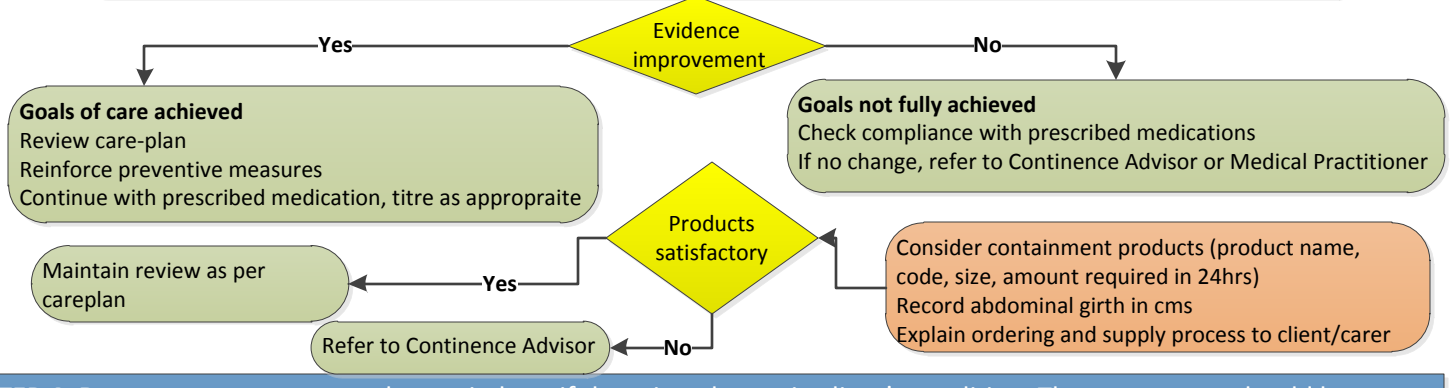
Faecal impaction
If symptoms suggest faecal impaction- refer immediately for medical assessment.

Hard stool - oral or rectal stool softening medication as prescribed by Medical practitioner/ANP.
Soft stool - oral or rectal bowel stimulant as prescribed by Medical practitioner/ANP.
Maintenance- aim to establish regular bowel habit (Bristol stool type 4)

Preventive measures

1. Fluid intake
2. Dietary intake
3. Mobility
4. Medication review
5. Access to toilet
6. Equipment
7. Privacy
8. Pain
9. Psychological issues
10. Medical condition

Improvement aim: establish regular bowel pattern



STEP 4: Repeat assessment must be carried out if there is a change in client's condition. The assessment should be completed face - to - face where possible. Documentation adhere to professional guidelines

References: NICE Faecal Incontinence in Adults clinical guideline 49 2007, reviewed June 2018 and unchanged