Guidance for completion of adult bowel assessment

	Suggested question/discussion	Clinical rational
1.	**Presenting problem** Ask the individual what problems they are experiencing with their bowel control? What bothers about your bowels? How long have you had these problems? When did the problems start? Is it a new problem? or have they previously had bowel problems? Can you think of anything that happened in your life about the time your problems started? Why seek help now? What are your expectations?	 To understand the "bowel problem" from the individual's perspective. What terminology do they use when talking about their problems? What is their level of understanding? www.nhs.uk/conditions/bowel-incontinence.– u tube Christine Norton?? Constipation can be a recurrent problem. Look for clues to help you understand their problem, you may need to probe. Was it related to traumatic child birth, haemorrhoidectomy, change of medication, menopause? It takes courage to come forward and ask for help for bowel problems. What are the individual's own goals
2	**Medical/Surgical History** Ask the patient questions to gain an understanding of their medical conditions. Consider conditions that can affect bowel control: Neurological conditions, including Multiple Sclerosis, spinal cord injury, Parkinson's Disease, Stroke, Diabetes. Previous bowel surgery, if yes when and what surgery? Anal surgery or trauma, including anal sex.	 Medical conditions can affect bladder control. Are other health professionals involved with their care? Refer back to causes of faecal incontinence. Increase bowel movements is a symptom of hypothyroidism. Reduced bowel movements and constipation are symptoms of Hypothyroidism as the metabolic rate slows throughout the body. Major bowel surgery or radiotherapy could affect bowel function. Anal surgery/trauma could damage the internal anal sphincter causing passive incontinence.

	Gynaecological surgery, including abdominal hysterectomy	Problems with constipation difficulties and infrequent defaecation reported following hysterectomy.
4	**Bowel Investigation** Ask questions to identify if they have had any bowel investigations including:	
	- Barium Enema	An x-ray to detect changes or abnormalities in the colon.
	- Sigmoidoscopy	Sigmoidoscopy is an examination of the rectum and sigmoid colon used to investigate cause of bleeding or pain from the back passage. It can be used to remove polys, to look for evidence of inflammation or cancer in the rectum or lower colon and to take biopsies.
	- Colonoscopy	Colonoscopy is an Examination of the colon; the scope can be pushed round the colon back as far as the caecum. It can diagnose conditions: ulcerative colitis, Cohn's disease, diverticula, colonic polyps, colorectal cancer.
	- Anal Ultra Sound	Anal ultra sound is an examination using high frequency sound waves to create images of the tissues beneath the surface. It provides additional information about rectal polyps, rectal cancer, sphincter muscle injuries, scars or tears, anal fistulas and perianal infection.
	- Anal Manometry	Anal manograph measures the strengths of the internal and external sphincters, the co-ordination of the pelvic floor muscles and assesses sensations in the rectum. It is used to identify anal sphincter damage, assess constipation/ faecal incontinence and to rule out conditions like Hirschsprung's disease.
	- Biofeedback pelvic floor muscle training	Biofeedback muscle training is a treatment for faecal (and urinary) incontinence and constipation, to help individuals to strengthen or relax pelvic floor muscles. Special sensors display the muscle activity on a computer screen and feedback is given to help the individua to gain control of their pelvic

		floor muscle function, to teach them how to stop using incorrect muscles and start using the correct pelvic floor muscles.
	- Pudendal nerve EMG (electromyographic evaluation)	Pudendal nerve EMG assess conduction of the pudendal nerve where there is neuropathy, which is associated with anal sphincter defects particularly in older women.
	if yes, to any of the above, ask questions to understand who conducted the tests, the results and treatment outcomes.	
3	**Obstetric History** Ask questions to understand about their obstetric history, including the high-risk factors for anal sphincter damage:	Research estimates 5%% of women have trouble controlling wind or bowel movements after childbirth in the UK. Ref: R. Mackenzie, A. Clubb, "Faecal incontinence following childbirth" Nursing Times June 3, 2007.
	- Number of pregnancies/ babies	Anal sphincter laceration is strongly predicted with first vaginal delivery
	- Forceps delivery	Anal incontinence is associated with forceps delivery.
	- Episiotomies	Episiotomies were performed for nearly all vaginal births for women having their first babies as it was thought that it was better for the mother and baby. Scientific evidence has seen proved the exact opposite, not only does an episiotomy not protect the pelvic floor function, it actually greatly increases the potential for a serious complication of vaginal anal sphincter 3rd or 4th degree tears, which damage the anal sphincter.
	- 3rd and 4Th degree tears	A 3rd degree laceration is a tear in the vaginal tissue, perineal skin and the perineal muscle that extend into the anal sphincter, therefore damaging the muscle that control the anus. A 4th degree tear goes though the anal sphincter and the tissue underneath it, it extends to the anus and rectum.
	- Birth weight over 4kgs 8.5lb	High birth weight babies is associated with anal sphincter damage.

	- Maternal age over 30	Research suggests that women having their first baby later in life are more at risk of pelvic floor injury during vaginal birth. Muscles and ligaments become less stretchy with age which makes them more likely to tear during childbirth.
4	**Relevant medication** Record all medications, prescribed and over the counter. Ask questions to check if they are or have been taking over the counter laxatives and analgesics. Identify if they are taking drugs that could affect their bowel control, the main ones are:	Drugs or their side effects can affect bowel function.
	- Laxatives	Laxative abuse is main cause of diarrhoea, Over the counter laxatives are commonly taken.
	- Analgesics	Constipation is a common side effect of analgesics. Laxatives co-prescribed with opioids to reduce risk of opioid induced constipation.
	- Anti-depressant	Constipation is a side effect of Tricyclic antidepressants. Diarrhoea or constipation are side effects of the Selective serotonin uptake inhibitors (such as, Fluoxetine, Citalopram or Sertraline) and the Serotonin-noradrenaline reuptake inhibitors (such as Yentreve or Venlafaxine)
	- Anti-cholinergic	Constipation is a side effect. The Anticholinergics have been linked for a long time with cognitive impairment (dementia) and the risk of falls, but more recently they are linked with increased mortality and morbidity and may cause constipation and urinary retention. Do you know about the **Anticholinergic Burden** and the **Anticholinergic Risk Scale?**
	- Antibiotics	Severe watery type 6-7 diarrhoea is a common side effect of antibiotics.
	- Non-steroidal anti-inflammatory	**Clostridium Difficile** is a bacterium that can affect the large bowel and cause colitis and profuse watery diarrhoea

		which can contain blood and pus. It affects individuals who have been treated with broad spectrum antibiotics. Non- Non-steroidal anti-inflammatory medications (such as Diclofenac, Ibuprofen), side effects diarrhoea, constipation, risk of intestinal bleeding and ulcers. Use with caution with Inflammatory Bowel Disease.
5	**Fluid Intake** Discuss the type, amount and pattern of drinks over 24hours. Ask questions to understand about dietary intake: - Number and regularity of meals - Do they have breakfast? - Types of food eaten at each meal - Dietary fibre, how many portions of fruit, vegetables, wholegrain cereals - Food allergies Food diary, for 7 days, can is a useful tool to assess diary intake.	Too little or too much fluid can affect bowel function. Laxatives including Fybogel, Macrogols or Lactulose do not work effectively with low fluid intake. Increasing dietary fibre with low fluid intake will exacerbate constipation. Gastrocolic reflex. Are they having the correct amount of dietary fibre? Too much fibre can cause loss stool and urgency. Too little fibre can cause constipation.
6	**Known Allergies**	Harm free care
7	**Present bowel pattern** Ask questions to understand the individual's present bowel pattern: - Frequency - Time of day bowels open - Consistency of stool using the Bristol Stool chart - Bowel routine? - Do they take anything or do anything to that make them go? - Colour of stool? - Pain on defaecation? - Blood or mucous present?	To identify if they have a normal type 3-4 stool. Type 1-2 (hard pellets)could indicate constipation or slow transit. Type 6-7 could indicate constipation with overflow or diarrhoea and loose Stool increases the risk of both urge and passive incontinence Frequent loose stool and urgency, especially with blood and mucous could indicate Crohn's disease or Ulcerative Colitis, consider **referral** on. Alternating loose stool with constipation could indicate Irritable Bowel Syndrome, consider **referral** on. Major bowel surgery or radiotherapy can cause unpredictable bowel habit.

		Pain with urge to defaecate could indicate Inflammatory or Irritable bowel syndrome, consider **referral** on. Pain on passing stool could indicate haemorrhoids or fissures, this indicates **referral** on. Streaks of fresh blood could indicate haemorrhoids, fissures or polyps Dark or bright red blood could indicate cancer, this indicates **referral** on. Blood, mucous and a history of straining could indicate Solitary Rectal Ulcer. Copious mucous could indicate villous adenoma, this indicates **referral** on
	- Can they control flatus? - Can they distinguish between stool and flatus?	These questions examine the function of the anal sphincter, can it maintain this seal? If the answer is "no" this suggests damage to the hypogastric plexus which is involved in the sampling reflex.
	Has there been any significant recent changes to their bowel habit (especially over 40 years old)?	A significant change in bowel habit indicates **referra**l on, as it could indicate cancer.
8	**Symptoms of Urge Incontinence –** main symptoms are: unable to hold, urgency +/- faecal incontinence. Key questions to consider: Q. When you get the feeling, you need to open your bowels how long can you hold for? - not at all - up to 2 minutes - up to 5 minutes - longer than 5 minutes Q. Do you get urgency? Q. Do you ever fail to reach the toilet in time and have an accident with your bowels? if yes, Q. how often does this happen?	Urge incontinence is a defect or weakness of the external anal sphincter, causes include obstetric trauma, diarrhoea, neurological condition. With normal anal sphincter pressure defaecation can be deferred for long periods of time because pressure of the external sphincter is greater than pressure of rectal contractions and when sampling occurs retrograde peristalsis moves the stool back up into the sigmoid colon and the urge diminishes. If "not at all" or only up to 2 minutes, this suggests a problem with the anal sphincter or very loose stool.
9	**Symptoms of Passive Incontinence –** main symptoms are: leakage of loose/soft stool after defaecation with no awareness. Key questions to consider: Q. Do you have any leakage from your back passage that you are not aware of? If yes,	Passive incontinence is a defect or weakness of the internal sphincter, causing an ineffective closure of the anal sphincter. Symptoms are worse if stool is loose.

	Q. Is it liquid or solid? Q. When does it occur? After bowel movement/with physical activity/ anytime? Q. Do you have to repeatedly wipe yourself after a bowel action?	Physical activity, running /walking can provoke passive soiling. With passive soiling it is difficult to cleanse the anus. Soiling may persist for hours.
10	**Evacuation Difficulties –** the main symptoms are difficulty evacuating stool, straining, sensation of incomplete emptying Key questions to consider: Q. Do you have difficulty opening your bowels? Q. Do you have to strain? If yes how long for? Q. Do you need to insert a finger into your anus/vagina to be able to open your bowels? Q. Do you have a dragging feeling? Q. Do you feel you have emptied your bowels completely? Do you feel comfortable after opening your bowels?	Constipation is the most common defaecation difficulty, it is also a problem with neurological damage**.** A weak pelvic floor can cause evacuation problems. A rectocele can cause evacuation difficulties, inserting a finger into vagina can promote evacuation of the stool trapped by the rectocele.
11	**Symptoms of Diarrhoea** – ask questions to determine the type of stool passed, the amount, odour, how often and how long does it last frequency and to identify their understanding of "diarrhoea". Trigger factors? Review medications, including laxative and antibiotics. Digital examination to check it is not constipation with overflow. Do they have their bowels open during sleep?	To understand what diarrhoea means to them and make a clinical judgement, is **referral** on indicated to identify the cause? Constipation with over flow is a common and often missed, the overflow can be seen as diarrhoea. It is not normal to get the urge to defaecate during sleep, unless related to a night time feed. Consider **referral** on if no reason identified.
12	**Impact on Quality of life – talk to the individual:** - What is their attitude to their bowel problem? - How does it make them feel?	To identify and measure how their bowel problem is affecting all aspects of their life, what are their coping strategies?

	- Is it impacting on lifestyle, work, relationships, leisure activities? - Does the problem get you down? - Coping mechanisms - What worries you most? - How are they presently managing their bowel problem? (diet, medication, skincare, treatment regimens) - Use of containment products, if yes, what, how many, are they effective? - How much does your bowel problem affect your life? (not at all, a little, moderately, a lot) - Is their anything we have not talked about that is a concern to you?	Many individuals suffer in silence and will not have spoken to their loved ones about the answers they will give you, listening, trust, empathy and rapport are essential skills. Abuse may be disclosed. Worries about bowel cancer discussed. They may be avoiding sexual intimacy, feel dirty, fear of incontinence. Bowel problems can be very restrictive at work, planning holidays, smell, dealing with pads, physical activities. Isolation and depression are co-morbidities.
13	**Toilet Facilities and ability to use** Do you have any problem getting to or using the toilet? Do you use the toilet independently? Observation if the journey to the toilet and how they manage to use the toilet: -posture on the toilet – do their touch the floor? -ability to wipe – can they reach? -ability to undress/dress -ability to cope with pads/aids	Where toileting difficulties are identified observation of the individuals journey to and use of the toilet facilities (with their consent) is an essential part of the assessment.
14	**Physical assessment-** Inspection of the abdomen for signs of abdominal: - Distention - Bloating – build up of gas in stomach, small intestine or colon	Disturbance of bowel function can cause abdominal distension including; irritable bowel, constipation or lactulose intolerance, (other causes include ovary cyst, ascites). For some individuals, with severe constipation, hard lumps of stool can be, seem on lying or if felt on gentle palpation in the region of the descending colon. Consumption of high fibre foods can cause bloating

	Inspection of the perineal skin: - Healthy - Rashes, soreness, itchiness - Skin tags - Bleeding/ Haemorrhoids - Rectal prolapse	Partial rectal prolapse initially occurs after a bowel movement and usually retracts when the individual stands up, examination when sat on the toilet is required to observe the prolapse.
	- Faecal soiling - Faecal smearing	The majority of individuals who report faecal leakage are fastidious about hygiene, therefore this may not be observed on examination.
	- Gaping anus with buttocks parted	Could be related to repeated penetration into the anal canal by a digit, penis or object. It could be related to sexual abuse or anal sex.
	- Anal lesion - Infestation	
	Digital rectal examination – undertaken as with urinary incontinence problems, to identify if there is stool in the rectum, if yes, the type and amount and to assess anal tone.	When performing a digital rectal examination, a lubricated gloved finger is slowly inserted into the rectum, **did you know** - when the finger is withdrawn, the tightening you feel is the contraction of the anal sphincter? If this tightening is not felt this could indicate a defect in the internal anal sphincter.
13	**Analysis of Bowel chart** A bowel diary is an essential part of a bowel assessment, 7 days or more. Complete prior to assessment to enable the information to be analysed in conjunction at the time of the assessment and when the diagnosis is made. Clear instructions need to be given to support the individual to provide accurate and timely information. The information required from a bowel function is: - Date and time of all bowel movement - Type and amount stool passed (subjective assessment of amount) - Urgency?	The bowel dairy is a tool to support the diagnosis and can be repeated during treatment to assist with evaluation. The time period the chart needs completed for will be determined by the frequency of bowel movements, if bowels only opened every 7 days then 3-4 weeks of charting may be required.

	- Straining? - Bowel accident/leakage, including type and amount - Pad / clothing changed	
15	**Continence Diagnosis for bowel problem:** **At the end of the assessment the assessor needs analyse all the information and make a diagnosis:** - **Urge incontinence** - **Passive incontinence/soiling** - **Diarrhoea** - **Constipation/evacuation difficulty** - **Incontinence of flatus** - **Nocturnal incontinence** - **Functional/cognitive difficulty.**	For some individuals the diagnosis for the bowel problem will clear and conservative treatment can be implemented. For others referral on will be indicated for medical/specialist assessment. But all individuals, including those who are being referred on, can be offered practical advice and support which will be explored in week 5, conservative treatments.