RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
NURSING BEST PRACTICE GUIDELINES PROGRAM

Transdisciplinary Patient/Client Bowel Assessment Tool

PERSONAL DATA Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
Date of Birth YYYY / MM / DD Age Gender ❑ Male ❑ Female		
BOWEL HISTORY		
▸ What caused you to seek this consultation?		
▸ When did these symptoms start?		
▸ What do you think caused the onset of the symptoms?		
BOWEL ELIMINATION PATTERNS		
▸ How often do your bowels move?		
Any recent change?		
▸ Are your stools difficult or painful to pass? ❑ Yes ❑ No		
Describe:		
▸ Do you have to strain at stool? ❑ Yes ❑ No		
STOOL CONSISTENCY		
▸ What is your usual stool consitency (Bristol Stool Chart)? ❑ Separate hard lumps difficult to pass ❑ Sausage shaped but lumpy ❑ Like a sausage but with cracks on its surface ❑ Like a sausage or snake, smooth and soft ❑ Soft blobs with clear cut edges, passed easily ❑ Fluffy pieces with ragged edges, mushy stool ❑ Water no pieces, entirely liquid		
FECAL INCONTINENCE		
▸ How often?		
▸ How much?		

FECAL INCONTINENCE Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ When your bowels need to move, do you need to rush to the toilet? ❑ Yes ❑ No		
How long can you hold it for?		
▸ Do you ever fail to reach the toilet in time and have a bowel accident (urge incontinence)? ❑ Never ❑ Seldom ❑ Sometimes ❑ Frequently		
▸ Do you ever have soiling after your bowels move (post defecation soiling)? ❑ Yes ❑ No ❑ Sometimes		
▸ Do you ever have any fecal leakage of which you are unaware (passive soiling)? ❑ Yes ❑ No ❑ Sometimes		
▸ Do you have difficulty wiping (e.g. wipe repeatedly requiring a lot of toilet tissue)? ❑ Yes ❑ No ❑ Sometimes		
▸ Do you have any fecal leakage with exercise or exertion? ❑ Yes ❑ No ❑ Sometimes		
FLATUS		
▸ Are you able to tell the difference between gas and the need to move your bowels? ❑ Yes ❑ No		
▸ How would you describe your ability to control gas (flatus)? ❑ Good ❑ Variable ❑ Poor		
ABDOMINAL PAIN ASSOCIATED WITH BOWELS		
▸ Do you have pain associated with moving your bowels? ❑ Yes ❑ No		
▸ Does the pain occur before moving your bowels? ❑ Yes ❑ No		
▸ Is pain relieved by moving your bowels? ❑ Yes ❑ No		
▸ Do you experience pain as you pass a stool? ❑ Yes ❑ No		
▸ Do you experience other pain? ❑ Yes ❑ No		
▸ Do you pass any blood or mucous when your bowels move? ❑ Yes ❑ No		
EVACUATION DIFFICULTIES		
▸ Do you have difficulty moving your bowels? Do you need to strain? ❑ Yes ❑ No How long do you need to strain?		
▸ Do you ever need to insert a finger into your anus/vagina to help pass stool? ❑ Yes ❑ No Do you need to push on the area by your anus? ❑ Yes ❑ No		
▸ Does it feel as if you have not completely emptied your bowels (incomplete evacuation)? ❑ Yes ❑ No		

EVACUATION DIFFICULTIES Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you have a dragging feeling or a perception that the rectum protrudes from the anus? ❑ Yes ❑ No		
PADS/PANTS		
▸ Do you wear a pad due to leakage from your bowel? ❑ Yes ❑ No		
What type of pad?		
▸ How many pads do you use in 24 hours?		
▸ Do you need to change your underwear due to fecal leakage? ❑ Yes ❑ No		
MEDICATIONS (**bowel medications)		
MEDICAL HISTORY		
▸ Previous bowel treatments and results:		
FLUID INTAKE		
▸ Do you restrict your fluids? ❑ Yes ❑ No ❑ Sometimes		
▸ How much do you drink in a day, including water? (Describe in cups [1 cup = 250 mL]) Breakfast _____ cups Mid-morning _____ cups Lunch _____ cups Mid-day _____ cups Supper _____ cups Evening _____ cups DAILY TOTAL = _____ cups		

RISK BEHAVIOURS Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you drink beverages containing caffeine? ❑ Yes ❑ No If YES, state amount _____ cups per day		
▸ Do you drink any alcoholic beverages? ❑ Yes ❑ No If YES, state amount _____ drinks per day		
▸ **Childbirth** Have you experienced childbirth? ❑ Yes ❑ No If YES, total number of deliveries _____ With your vaginal deliveries, did you have 1. Forceps ❑ Yes ❑ No 2. Breech ❑ Yes ❑ No 3. Posterior ❑ Yes ❑ No 4. Tears ❑ Yes ❑ No 5. Episiotomy ❑ Yes ❑ No 6. Prolonged labour ❑ Yes ❑ No 7. Heavy babies ❑ Yes ❑ No Caesarean section? ❑ Yes ❑ No		
▸ Is diet used to keep your bowels regular? ❑ Yes ❑ No If YES, specify:		
PSYCHOSOCIAL		
▸ How does this condition affect your lifestyle/relationships?		
▸ Describe the emotional/psychological effects of this condition:		
PHYSICAL ASSESSMENT Scope of Practice | Continence Advisor | RN | RPN		
Female		
▸ Atrophic vaginal changes noted on visual inspection ❑ Yes ❑ No		
▸ Vaginal discharge ❑ Yes ❑ No If YES, swab sent ❑ Yes ❑ No Results:		
Cystocele ❑ Grade I – Small ❑ Grade II – Moderate ❑ Grade III – Beyond Introitus ❑ Absent ❑ Not assessed		

PHYSICAL ASSESSMENT Scope of Practice | Continence Advisor	Initials / Designation	Date yyyy/mm/dd
Rectocele ❑ Yes ❑ No		
Able to contract pelvic floor ❑ Yes ❑ No		
Circumvaginal muscle strength (Oxford Scale) ❑ Nil ❑ Flicker ❑ Weak ❑ Moderate ❑ Good ❑ Strong ❑ Not done		
PHYSICAL ASSESSMENT Scope of Practice | Continence Advisor		
Rectal Examination Perianal sensation ❑ Present ❑ Reduced ❑ Absent Anal tone ❑ Present ❑ Reduced ❑ Absent		
CONTRIBUTING FACTORS		
TYPE OF PROBLEM		
1. Constipation ❑ 2. Fecal urgency and urge incontinence related to: ❑ a. reduced external anal sphincter tone ❑ b. increased peristalsis stool ❑ 3. Passive Incontinence ❑ a. Related to rectocele ❑ b. Related to weak internal anal sphincter ❑ 4. Possible Irritable Bowel Syndrome ❑		
TREATMENT		
1. Bowel diary x 7 days ❑ 2. Bowel routine ❑ 3. Kegel pelvic floor exercises ❑ 4. Fluid intake changes ❑ 5. Caffeine reduction ❑ 6. Bulking agent ❑ 7. Incontinence product education ❑ 8. Caregiver instruction ❑ 9. Other:		

NOTES

SOAP LEGEND **S** = Subjective **O** = Objective **A** = Analysis **P** = Plan

Date	Time	Discipline	SOAP Notes

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