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

Acknowledgement

The Registered Nurses' Association of Ontario (RNAO) and the Nursing Best Practice Guidelines Program would like to acknowledge the following individuals and organizations for their contributions to the development of the *Transdisciplinary Patient/ Client Bowel Assessment Tool.*

- **Barbara Cassel, RN, BScN, MN, GNC(C), NCA,** who developed this resource as an extension of her ongoing commitment to implementation of RNAO's Nursing Best Practice Guidelines.
- West Park Healthcare Centre, recipient of the RNAO Best Practice Spotlight Organization (BPSO) designation, recognizing an ongoing commitment to supporting, implementing and evaluating RNAO Best Practice Guidelines.
- The RNAO *Prevention of Constipation in the Older Adult Population* development panel who developed the guideline on which this resource is based.

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Transdisciplinary Patient/Client Continence 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		
INCONTINENCE HISTORY		
▸ Type ❑ Urinary Incontinence ❑ Fecal Incontinence ❑ Both ❑ Other		
▸ Onset ❑ Sudden ❑ Gradual		
▸ Duration ❑ < 6 months ❑ 6 months - 1 year ❑ 1-2 years ❑ 2-5 years ❑ > 5 years		
▸ Incontinence over the past 6 months ❑ Worsening ❑ Stable ❑ Improving ❑ Fluctuates		
▸ What do you think has caused the problem?		
▸ How often do you go to the toilet during the day?		
▸ Do you have any accidents during the waking hours? ❑ Yes ❑ No If Yes, how often? ❑ < 1 day ❑ 1 per day ❑ 1 per week ❑ 2-6 per week ❑ 1 per month ❑ Not known		
▸ Does urine or feces ❑ Soil/wet underwear only ❑ Soil outer clothing ❑ Run down your legs ❑ Pool on the floor ❑ Remain within containment product		
▸ Is the amount ❑ Consistent ❑ Variable		
▸ Does the need to go wake you up? ❑ Yes ❑ No		
▸ How often do you go to the toilet after going to bed?		
▸ Do you have accidents at night? ❑ Yes ❑ No If Yes, how often? ❑ 1 per night ❑ >1 per day ❑ 1 per week ❑ 2-6 per week ❑ 1 per month ❑ Not known		
▸ How much leakage? ❑ Wets/soils incontinent product ❑ Wets/soils night attire ❑ Wets/soils bedding ❑ Additional soiling		
▸ Do you leak urine or feces with physical stress (I.e., Cough, laugh, sneeze, lift, jump)? ❑ Yes ❑ Yes, just after ❑ Occasionally ❑ Not known ❑ No		
▸ Do you have to rush to the bathroom when you feel the urge? ❑ Yes ❑ No ❑ Occasionally ❑ Not known		
▸ On average, how long can you hold on after feeling the first urge? ❑ Not at all ❑ < 5 minutes ❑ 5-15 minutes ❑ >15 minutes ❑ Varies ❑ Not known		

INCONTINENCE HISTORY Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you feel that you completely empty your bladder when you pass urine? ❑ Yes ❑ No		
▸ Are you aware of the urge to void or move your bowels? ❑ Yes ❑ No ❑ Not known		
▸ Are you aware of passing urine? ❑ Yes ❑ No ❑ Not known		
▸ Are you aware when wet/soiled? ❑ Yes ❑ No ❑ Not known		
BLADDER		
▸ Do you have: 1. Hesitancy ❑ Yes ❑ No ❑ Not known 2. Straining/manual expression ❑ Yes ❑ No ❑ Not known 3. Poor stream ❑ Yes ❑ No ❑ Not known 4. Dysuria (difficult or painful urination) ❑ Yes ❑ No ❑ Not known 5. Post-micturition dribble ❑ Yes ❑ No ❑ Not known 6. Constant dribble ❑ Yes ❑ No ❑ Not known 7. Change in odour of urine in past 6 months ❑ Yes ❑ No ❑ Not known 8. Hematuria (blood in urine) ❑ Yes ❑ No ❑ Not known		
▸ What type of product is used for containment? (specify) How many are used every 24 hours?		
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		
▸ Do you drink beverages containing caffeine? ❑ Yes ❑ No _____ cups per day		
▸ Do you drink any alcoholic beverages? ❑ Yes ❑ No _____ drinks per day		
BOWEL		
▸ What has been your bowel pattern in the last six months? ❑ Daily ❑ 2-3 times a day ❑ 3 times per week ❑ Other:		
▸ Is this a change from your previous normal pattern? ❑ Yes ❑ No If Yes, when did this occur?		
▸ Do you frequently have hard or difficult bowel movements? ❑ Yes ❑ No		
▸ Any detection of blood in your bowel movement? ❑ Yes ❑ No		
▸ Any pain with bowel movement? ❑ Yes ❑ No If Yes, describe:		

BOWEL Scope of Practice | Continence Advisor | RN | RPN	Initials / Designation	Date yyyy/mm/dd
▸ Do you have hemorrhoids? ❑ Yes ❑ No		
▸ Is diet used to keep your bowels regular? ❑ Yes ❑ No		
▸ Indicate product(s) or procedure(s) used for regulation: 1. Laxatives ❑ Yes ❑ No 2. Suppositories ❑ Yes ❑ No 3. Enemas ❑ Yes ❑ No 4. Manual disimpaction ❑ Yes ❑ No 5. Other (specify) ❑ Yes ❑ No		
▸ Do you have loose bowel movements? ❑ Yes ❑ No If Yes, how often?		
▸ Do any foods contribute to loose stools? ❑ Yes ❑ No If Yes, which food(s)?		

MEDICAL HISTORY Scope of Practice | Continence Advisor | RN | RPN			Initials / Designation	Date yyyy/mm/dd
▸ **Previous Surgery**	**When**	**Comments**		
Trans Urethral Prostatectomy (TURP)				
Abdominal Hysterectomy				
Vaginal Hysterectomy				
Bladder Repair				
Abdominal Peritoneal Resection				
▸ **Medical Conditions**	**Onset**	**Comments**		
Stroke (CVA)				
Parkinson's Disease				
Multiple Sclerosis				
Diabetes Mellitus				
Fractured Hip				
Urinary Tract Infection				
Cancer				
Glaucoma				
Renal Stones				
Dementia				
Arthritis				
Other (specify)				

MEDICAL HISTORY Scope of Practice | Continence Advisor | RN | RPN

Initials / Designation | Date yyyy/mm/dd

Abilities Assessment

Aware of urge to void	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Able to find the toilet	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Able to understand reminders or prompts	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Able to ask for assistance	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Able to remove clothing to toilet	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Able to sit on the toilet/ hold the urinal	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Motivated to be continent	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer
Socially aware of appropriate place to pass urine	❑ Yes	❑ No	❑ Occasionally	❑ Unable to answer

Childbirth

Have you experienced childbirth? ❑ Yes ❑ No If YES, total # 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

Menopause? ❑ Yes Age _____

Have you discussed your problem of incontinence with your family doctor? ❑ Yes ❑ No

Have you had any previous treatment for incontinence? ❑ Yes ❑ No

If YES, describe:

MEDICATION REVIEW Scope of Practice | Continence Advisor | RN | RPN

REVIEW MAR (Medication Administration Record)

Any medication with the following actions:

1. Anticholinergic	❑ Yes	❑ No
2. Cholinergic	❑ Yes	❑ No
3. Diuretics	❑ Yes	❑ No
4. Estrogen	❑ Yes	❑ No
5. Sedative/Hypnotic	❑ Yes	❑ No
6. Antidepressant	❑ Yes	❑ No
7. Antispasmodic	❑ Yes	❑ No
8. Antipsychotic	❑ Yes	❑ No

PHYSICAL ASSESSMENT Scope of Practice | Continence Advisor	Initials / Designation	Date yyyy/mm/dd
▸ Perineal Skin ❑ Intact ❑ Redness ❑ Excoriation ❑ Other:		
▸ Personal Hygiene uses soap ❑ Yes ❑ No		
▸ Voided Volume =		
▸ Residual urine ❑ Yes ❑ No Volume = _____ ❑ Catheterization ❑ Ultrasound Sent for culture/sensitivity? ❑ Yes ❑ No		
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		
Rectocele ❑ Yes ❑ No		
Able to contract pelvic floor ❑ Yes ❑ No		
Circumvaginal muscle strength (Oxford Scale) ❑ Nil ❑ Flicker ❑ Weak ❑ Moderate ❑ Good ❑ Strong ❑ Not assessed		
Male Epispadias ❑ Yes ❑ No Hypospadias ❑ Yes ❑ No Retracted penis ❑ Yes ❑ No		
Rectal Examination Perianal sensation ❑ Present ❑ Reduced ❑ Absent Anal tone ❑ Present ❑ Reduced ❑ Absent		
CONTRIBUTING FACTORS		

CATEGORY					Initials / Designation	Date yyyy/mm/dd
❑ Stress	❑ Urge	❑ Stress/urge	❑ Overflow	❑ Functional		
❑ Iatrogenic	❑ N/A	❑ Other:				
TREATMENT OPTIONS						
1. Prompted voiding			❑ Initiated	❑ N/A		
2. Kegel pelvic floor excercises			❑ Initiated	❑ N/A		
3. Urge suppression			❑ Initiated	❑ N/A		
4. Fluid intake changes			❑ Initiated	❑ N/A		
5. Caffeine reduction			❑ Initiated	❑ N/A		
6. Intermittent catheterization (self/caregiver)			❑ Initiated	❑ N/A		
7. Bedside commode			❑ Initiated	❑ N/A		
8. Caregiver instruction			❑ Initiated	❑ N/A		
9. Personal hygiene			❑ Initiated	❑ N/A		
10. Incontinence product education			❑ Initiated	❑ N/A		
11. Education about aids and appliances			❑ Initiated	❑ N/A		
12. Other:			❑ Initiated	❑ N/A		
REFERRAL						
▸ Referral to:						

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