Using national guidelines to support the assessment of lower bowel dysfunction

This article outlines the prevalence of bowel disorders, the assessment of bowel dysfunction and the tools used to collect data for assessment.

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This guided learning unit outlines how national guidelines can support the assessment of bowel function. It discusses the prevalence of bowel disorders, the tools used to collect data for assessment and outlines how to carry out a patient assessment.

Patients with bowel dysfunction require an extensive assessment to establish a differential diagnosis that will inform a patient-centred individual treatment plan.

There has been little guidance about the assessment of patients with bowel dysfunction. Continence assessment forms often focus on bladder dysfunction.

However, the profile of patients with bowel dysfunction has been raised with the publication of NICE (2007) guidelines on faecal incontinence and the Skills for Health (SfH) (2008) national occupational standards (NOS) for continence care, of which five relate to bowel dysfunction.

The RCN (2008) guidance for nurses on bowel care provides a review of lower bowel dysfunction in adults, expanding on the SfH competences relating to lower bowel dysfunction in a more usable format. It is currently being reviewed and updated.

These documents are aimed at all healthcare professionals and can be used as a benchmark. They provide support for those developing policies and procedures, and influence the care of patients with bowel dysfunction. This article on assessment incorporates these documents/guidelines, which are drivers to improving bowel care in all settings.

**BOWEL DISORDERS**

Faecal incontinence (FI) in adults is estimated to affect 2% of the population (Perry et al, 2002). Anal incontinence occurs more frequently in women than men and its incidence is grossly underestimated because of under-reporting (Sultan and Thakar, 2002). FI can dramatically disrupt people’s lives because they are unable to control the passage of faeces or flatus (Rockwood et al, 2000).

Depending on the individual’s continence status, diarrhoea may affect one person more than another. Patients may have acute diarrhoea that lasts for two to three days, or a more chronic problem that could be caused by, for example, food intolerance or *Clostridium difficile*.

Most people apply the term diarrhoea to loose or watery stools. Thus stool form, not frequency, defines diarrhoea. How often a symptom must occur for it to be considered significant depends on how bothersome it is to the patient (Longstreth et al, 2006).

Functional constipation is a bowel disorder that presents as persistently difficult, infrequent or seemingly incomplete defecation (Longstreth et al, 2006). It is estimated to affect one-third of the population in western industrialised countries (Klaschik et al, 2003). As with faecal incontinence, people experiencing constipation generally experience an impaired quality of life compared with the general population (Norton, 2006).

There is a debate over whether bowel and bladder function should be assessed separately. Kapoor et al (2008) found that, of 113 women who presented to a multidisciplinary pelvic floor clinic, 33 had combined urinary and faecal incontinence.

The assessment standard of the NOS for continence (CC01) addresses both bladder and bowel dysfunction to encourage healthcare professionals to give consideration to both problems (Addison, 2002).

**LEARNING OBJECTIVES**

1. Know about the different tools used in the process of assessment.
2. Identify the effect that faecal incontinence may have on a patient’s quality of life.

**BOX 2. PATIENT ASSESSMENT**

Ask the patient about the bowel problem. Consider the following:

- The main symptoms and how they bother the patient;
- Normal bowel habit;
- Stool consistency (use the Bristol Stool Chart – see right);
- Colour and smell of stool and presence of mucus, blood or undigested food;
- Pain on defecation;
- Problems with control – urgency to open bowels with bowel accidents, incontinence of faeces without being aware of flatus incontinence;
- Bloating;
- Abdominal pain;
- The need to undertake certain manoeuvres to help empty the bowel, for example supporting the perineum, digitating into the vagina or manual evacuation;
- Incomplete emptying – not feeling as if they have emptied the rectum completely but cannot empty any more;
- Straining to pass a stool;
- Effects on sexual function;
- Coping strategies – such as toilet mapping (planning journeys based on where toilets are), staying near toilets, using toilet substitutes, appliance use and containment.

*Clostridium difficile* is caused by, for example, food intolerance or a more chronic problem that could be caused by, for example, food intolerance or a more chronic problem that could be caused by.
1. Identify those who are at risk of having bladder and/or bowel dysfunction and initiate the continence assessment.

2. Respect the patient's privacy, dignity, wishes and beliefs, and seek to minimise embarrassment during the assessment.

3. Seek to reduce any communication barriers with patients and relevant others.

4. Explain the continence assessment and obtain consent.

5. Ask the patient to explain their bladder and/or bowel condition and its history in their own words, or obtain the history from an appropriate person who is accompanying them.

6. Seek to obtain a condition-specific history from the patient.

7. Obtain a list of the patient's medication, the rationale for use and the impact this has had on bladder and/or bowel activity.

8. Assess the impact of bladder and/or bowel dysfunction on the patient's lifestyle and quality of life.

9. Carry out baseline observations and tests, where necessary, to support the assessment.

10. Review and interpret charts and questionnaires to inform the assessment.

11. Carry out and interpret a systematic clinical examination as required.

12. Discuss with the patient and their carer(s) the: • Findings of the assessment; • Likely causes; • Implications (prognosis); • Risks and priorities identified; • Your conclusion and differential diagnosis; • The need for any further investigations.

13. Initiate further investigations and referral.

14. Provide the patient with relevant information and advice related to their condition and any further investigations.

15. Make a full, clear record of the assessment and any agreed follow-up action.

Source: Adapted from Skills for Health (2008)

**TOOLS USED TO COLLECT DATA FOR ASSESSMENT**
For a first planned assessment of bowel function, there are a number of tools that can be used to collect data about a patient. This includes a self-assessment questionnaire, with stool and food diaries, that can be completed by the patient before the clinic appointment.

There are advantages and disadvantages to self-assessment. Some of the advantages are that it:

- Allows the patient to think about their bowel problem and how it affects their quality of life in the comfort and privacy of their own home;
- Saves time for healthcare professionals, allowing them to concentrate on problem areas;
- Is cost-effective as it reduces the time patients spend in clinic;
- Allows more time to plan care and discuss this with the patient;
- Makes it easier for a patient to admit in person to using their fingers to help empty their bowel, either by performing a manual evacuation of faeces or supporting the perineum, if this is referred to on a form. They will become aware that it is something that other people may do.

Some disadvantages of self-assessment are that:

- Patients may not be able to read or understand;
- It may increase anxiety;
- Patients may find it time-consuming.

**WHO SHOULD CARRY OUT THE ASSESSMENT?**
Koch and Hudson (2000) suggested that poor nursing assessment can result in poor management of patients with bowel dysfunction or altered bowel habit.

The Department of Health (2001) suggested that ‘patients are assessed by professionals who have specific continence training’. NICE (2007) recommended that ‘people who report to have faecal incontinence should be offered care to be managed by healthcare professionals who have the relevant skills, training and experience’.

Healthcare professionals need to be competent to carry out an initial detailed assessment of faecal incontinence. The NOS CC01 Assess Bladder and Bowel Dysfunction (Skills for Health, 2008) sets out the performance criteria required (see Box 1).

**BOX 1. PERFORMANCE CRITERIA FOR ASSESSING BLADDER AND BOWEL DYSFUNCTION**

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3. Seek to reduce any communication barriers with patients and relevant others.

4. Explain the continence assessment and obtain consent.

5. Ask the patient to explain their bladder and/or bowel condition and its history in their own words, or obtain the history from an appropriate person who is accompanying them.

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**Brøst Stool Chart**

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Separate hard lumps, like nuts (hard to pass)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>Type 3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>Type 4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>Type 5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>Type 6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>Type 7</td>
<td>Watery, no solid pieces. Entirely liquid</td>
</tr>
</tbody>
</table>

To print out a full-page version of the Bristol Stool Chart, go to www.nursingtimes.net and click on Nursing Practice/Clinical Research.


WHAT TO INCLUDE IN THE ASSESSMENT FOR BOWEL DYSFUNCTION

Before assessing the patient, it is imperative that informed consent is gained and, due to the sensitivity of the problem, if there is a carer or relative present that the patient is happy for them to be involved (NICE, 2007).

The environment needs be conducive to the patient’s needs and to ensure that, where possible, their privacy and dignity is maintained. The assessment should be carried out with sensitivity to minimise the patient’s embarrassment.

It is essential to collect a thorough medical and social history from the patient. For example, an obstetric history will identify problems associated with childbirth that can have long-term consequences for bowel function.

Equally, assessment of drug history may identify excessive use of over-the-counter laxatives or drugs that can cause constipation, such as analgesics containing codeine. Neurological problems, such as multiple sclerosis, Parkinson’s disease, spina bifida or spinal injury, may result in bowel problems.

Details of information to collect about bowel dysfunction are listed in Box 2 (p16). Details on dietary and fluid assessment are outlined in Box 3.

Duration and triggers

It is important to identify whether the bowel dysfunction is acute (has been happening for less than three months) or chronic (more than three months). If there has been a change in the patient’s normal bowel habits that has lasted for four weeks or longer, ask if this is related to any change in their lifestyle.

Questions could cover such things as diet, fluids, medication (including herbal and over-the-counter), personal stresses such as a change in job, recent foreign travel (especially if a patient has diarrhoea) and surgery.

Also consider red-flag symptoms for bowel cancer, such as blood mixed in with stools, an increase in mucus and wind, weight loss without dieting, feeling tired and a family history.

Cognitive assessment

Patients with cognitive problems require careful assessment. For example, if a patient is unable to retain information or change behaviour, there is little point in teaching anal exercises to improve the strength of the pelvic floor muscles as these are unlikely to be carried out.

An assessment of cognitive function should include their ability to:
- Understand what is being explained;
- Retain information and learn;
- Change behaviour;
- Carry out instructions at home.

Anorectal examination

Digital rectal examination should be carried out by a healthcare professional who is competent. This can be used to establish the:
- Strength and movement of the anal muscles – resting tone of the internal anal sphincter, squeeze pressure of the external anal sphincter, length of squeeze and ability to relax on pushing down;
- Presence of faecal matter in the rectum, consistency and amount;
- Anal and rectal sensation;
- Need for rectal medication, manual evacuation;
- Observation of perianal area for the condition of the skin, any abnormalities and faecal soiling.

Treatment options can then be considered to resolve symptoms.

This can involve trial and error before a treatment that suits the patient is found (Baid, 2006). The patient will need a review assessment in order to establish whether the treatment plan that they have been given for their bowel dysfunction has been successful.

REFERENCES

Skills for Health (2008) CC01 Assess Bladder and Bowel Dysfunction. Bristol: SfH. tinyurl.com/nosbladder-bowel