National Audit of Continence Care 2010

Clinical Proforma for Bowel Problems – Faecal Incontinence
please answer ALL questions
(one proforma to be completed per patient/resident).

Your Site Code

Instructions for completion:
1. Please use a black or blue pen for all sections.
2. Please cross the boxes as appropriate (✔️ or ❌).

If you are unclear of any questions on this form please use the accompanying help booklet.

All enquiries should be sent, quoting your site code, to:
Tel: 020 3075 1347 / 020 3075 1619 / 020 3075 1511 or e-mail: nacc@rcplondon.ac.uk

AUDITOR DISCIPLINE
Select main discipline for this case:  ☐ Doctor  ☐ Nurse  ☐ Therapist  ☐ Manager

☐ Other

DEMOGRAPHIC INFORMATION

A. Patient audit number

B. Age (years)

C. Sex  ☐ Male  ☐ Female

D. Ethnicity:  ☐ White British  ☐ Other  ☐ Not recorded

E. Is English the primary language of the patient?  ☐ Yes  ☐ No  ☐ Not known  ☐ Not documented

F. Please indicate in which care setting this patient is in? (choose one only)

☐ Care home (residential & nursing)  ☐ Patient of local continence service

☐ Community dwelling in-patient  ☐ other (please specify):

☐ In-patient of primary care trust run hospital

☐ Patient of acute trust hospital
1. SYMPTOMS
1.1 How often is the patient incontinent of faeces?
- Every day/night
- Less than once weekly
- More than once weekly

1.2 What other relevant conditions does the patient have either currently or in the past? (select all that apply)
- Anorectal surgery
- Colorectal carcinoma
- Cervical myelopathy
- Dementia
- Diabetes
- Diverticular disease
- Faecal loading or chronic constipation
- Impaired mobility
- Inflammatory bowel disease
- Irritable bowel syndrome
- Neurological disease
- Pelvic radiotherapy
- Pelvic surgery
- Spinal cord disease/trauma
- Stroke
- Trauma at childbirth (women only)
- Urinary incontinence
- No documentation of these
- Other (please specify)

1.3 Is there documented evidence that the following factors have been identified in this case? (answer all questions)
1.3i Faecal incontinence related to colorectal faecal loading
- Yes
- No
- Nothing Identified
1.3ii Faecal incontinence related to functional disability
- Yes
- No
- Nothing Identified
1.3iii Faecal incontinence due to loss of cognitive awareness
- Yes
- No
- Nothing Identified
1.3iv Faecal incontinence related to co-morbidity
- Yes
- No
- Nothing Identified
1.3v Anorectal incontinence (weak anal sphincters or anorectal condition)
- Yes
- No
- Nothing Identified

2. ASSESSMENT
History
2.1 Is there documented evidence of a bowel history?
- Yes
- No
(If NO go to 2.2)
2.1i If yes, does the history of faecal incontinence include:
- Duration of symptoms
- Daytime symptoms
- Nocturnal symptoms

2.2 Is there documented evidence that a stool diary or bowel chart has been used to record frequency of incontinence?
- Yes
- No

2.3 Is the patient incontinent of urine?
- Yes
- No
(If NO go to 2.4)
2.3i If yes, is the patient catheterised because of incontinence?
- Yes
- No

2.4 Is the patient on medication that exacerbates faecal incontinence?
(See help notes for types of medication)
- Yes
- No
(If NO go to 2.5)
2.4i Has this medication been altered to minimise its impact?
- Yes
- No
- Not able to minimise further

2.5 Is there evidence that the impact of symptoms on quality of life have been recorded?
(If NO go to 2.6)
- Yes
- No
- No, but the patient is mentally incompetent to undergo an assessment.
2.5i If yes, has a standardised assessment scale been used e.g. Faecal Incontinence Quality of Life Scale?
Cognitive status

2.6 Has the patient’s cognition been assessed?  ○ Yes  ○ No  ○ Not documented
(see help notes for guidance)
(If YES answer ALL / If NO or Not documented answer 2.6i and proceed to 2.7)

2.6i Is the patient’s cognitive status:
○ Unimpaired  ○ Mild  ○ Moderate  ○ Severe  ○ Insufficient information to calculate
(see help notes for guidance)

2.6ii Is there documented use of a formal scoring system for assessment of cognition?
○ Yes  ○ No
(see help notes for guidance)

Functional status

2.7 Has the patient’s functional ability been assessed?  ○ Yes  ○ No  ○ Not documented
(see help notes for guidance)
(If YES answer all / If NO or Not documented answer 2.7i and proceed to 2.8)

2.7i Is the patient’s functional status:
○ Unimpaired  ○ Mild  ○ Moderate  ○ Severe  ○ Insufficient information to calculate
(see help notes for guidance)

2.7ii Is there documented use of a formal scoring system for assessment?
○ Yes  ○ No
(see help notes for guidance)

EXAMINATION

Basic examination
(for guidance on what constitutes “basic examination” see help notes)

2.8 Is there documented evidence of rectal examination to exclude faecal loading?
○ Yes  ○ No  ○ No, but the patient has a colostomy or some other form of faecal diversion

Focused examination
(for guidance on what constitutes “focused examination” see help notes)

2.9 Is there documented evidence that a focused examination has been performed?
○ Yes  ○ No  ○ No, but specialist records unavailable for audit
(If NO go to 2.10)

2.9i If yes, who has performed the examination?  Choose one only:
○ Geriatrician  ○ Therapist
○ Gynaecologist (women only)  ○ Urologist
○ GP  ○ Hospital ward based doctor
○ Nurse  ○ Gastroenterologist
○ Other
(please specify)

2.9ii If yes, is there documented evidence of the following (answer all questions)

2.9ii a Assessment of mobility  ○ Yes  ○ No  ○ Not required
2.9ii b Examination of the abdomen for palpable mass or bladder retention  ○ Yes  ○ No  ○ Not required
2.9ii c Examination of perineum and anus.  ○ Yes  ○ No  ○ Not required
2.9ii d Rectal examination  ○ Yes  ○ No  ○ Not required
2.9ii e Bowel imaging  ○ Yes  ○ No  ○ Not required
2.9ii f Neurological examination, if neurological symptoms suspected  ○ Yes  ○ No  ○ Not required

Diagnosis

2.10 For which tests is there documented evidence to aid diagnosis?

2.10i Stool culture  ○ Yes  ○ No  ○ No, but specialist records unavailable for audit  ○ Not required
2.10ii Abdominal x-ray  ○ Yes  ○ No  ○ No, but specialist records unavailable for audit  ○ Not required
2.10iii Colonoscopy  ○ Yes  ○ No  ○ No, but specialist records unavailable for audit  ○ Not required
2.10iv Other (please specify)

2.11 Is there documented evidence of a clear identification of the types or causes of bowel problem?
○ Yes  ○ No  ○ No, but specialist records unavailable for audit (relevant to care homes)
3. MANAGEMENT

Treatment

3.1 Is there documented evidence that condition-specific intervention has been given or planned for the following: (see help notes for guidance)

3.1i Faecal loading? ☐ Yes ☐ No ☐ Not applicable
3.1ii Potentially treatable causes of diarrhoea? ☐ Yes ☐ No ☐ Not applicable
3.1iii Rectal prolapse or third-degree haemorrhoids? ☐ Yes ☐ No ☐ Not applicable
3.1iv Acute anal sphincter injury? ☐ Yes ☐ No ☐ Not applicable
3.1v Acute disc prolapse/cauda equina syndrome? ☐ Yes ☐ No ☐ Not applicable

3.2 Are the patient's goals for treatment recorded? ☐ Yes ☐ No

3.3 Did the patient require treatment? ☐ Yes ☐ No

3.4 Did the patient have a treatment plan? ☐ Yes ☐ No

If you answered 'NO' to both 3.3 & 3.4 go to 3.6 otherwise answer 3.5

3.5 Which of the following methods of treatment have been used or planned? (select all that apply)

3.5i Advice on general health
3.5ii Advice on lifestyle
3.5iii Antidiarrhoeal drugs
3.5iv Biofeedback
3.5v Bowel clearance programme
3.5vi Bowel retraining
3.5vii Dietician
3.5viii Faecal incontinence chart
3.5ix Implementation of bowel training regimes / techniques
3.5x Improved mobility
3.5xi Improved quality of, and access to, toilet facilities
3.5xii Pelvic floor training
3.5xiii Laxatives / enemas/ suppositories
3.5xiv Management of behavioural problems in severe dementia
3.5xv Review of medication
3.5xvi Rectal irrigation
3.5xvii Specific pharmacological interventions, e.g: metronidazole for *C. difficile*
3.5xviii Colostomy or ileostomy
3.5xix Surgery
3.5xx Toileting advice
3.5xxi Toileting schedules
3.5xxii Treatment of co-morbidities
3.5xxv Other (please specify)
3.6 Is there documented history of referral to other providers of treatment? (select all that apply)
- Colorectal surgeon
- Bowel dysfunction practitioner
- Continence practitioner (see help notes for guidance)
- Dietitian
- Gastroenterologist
- General practitioner (GP)
- Geriatrician
- Neurologist
- Practice nurse
- Unable to retrieve data, records not available on site (Care Homes Only)
- Not documented
- Other (please specify) None of the above

3.7 Is there documented evidence that long-term management of Faecal Incontinence has been given or planned? (answer all questions)

3.7i Advice and information on continence products
- Yes
- No
- Not required

3.7ii Advice on skin care
- Yes
- No
- Not required

3.7iii Advice relating to preservation of dignity
- Yes
- No
- Not required

3.7iv Advice relating to preservation of independence
- Yes
- No
- Not required

3.7v Contact details for relevant support groups
- Yes
- No
- Not required

3.7vi Periodic review of symptoms
- Yes
- No
- Not required

3.7vii Psychological and emotional support
- Yes
- No
- Not required

3.8 Which of the following methods of management have been used or are planned for treatment? (select all that apply)
- Adapted clothing
- Pads
- Advice on skin care and odour control
- Not documented
- Anal plugs
- Other (please specify)
- Bags
- None of the above
- Devices to aid toileting (see help notes)

4. CARE PLAN / COMMUNICATION

4.1 Does the patient have a documented continence care plan? (see help notes for guidance)
- Yes
- No

4.1i If yes, when was the patient's care plan last reassessed?
- Less than 6 months
- 6-8 months
- 9-11 months
- 12 months or more
- No documentation of reassessment

4.2 Is there documented evidence that a copy of the care plan has been given to the patient?
- Yes
- No
- No, but the patient is mentally incompetent

4.3 Is there documented evidence that a copy of the care plan has been given to the carer/relative?
- Yes
- No
- No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion
Communication / Information

4.4 Is there documented evidence of a full discussion with the patient of the causes and treatments of the bowel problem?

☐ Yes ☐ No ☐ No, but the patient is mentally incompetent to participate in such discussion

4.5 Is there documented evidence of a full discussion of the causes and treatments of the bowel problem with the carer/relative?

☐ Yes ☐ No ☐ No, but the patient has either no relevant carer/relative, does not wish the carer/relative to be informed or is mentally incompetent to partake in such discussion