

## CC01 Assess bladder and bowel dysfunction

### OVERVIEW

This standard covers the specialist assessment of bladder and bowel dysfunction. It includes obtaining a history and carrying out relevant clinical examinations. It also includes carrying out and interpreting relevant baseline observations and tests. You will need to discuss the findings of the assessment with the individual and relevant others, and initiate further investigations and onward referral where required. Users of this standard will need to ensure that practice reflects up to date information and policies. Version No 1

### KNOWLEDGE AND UNDERSTANDING

You will need to know and understand:

1. the current European and National legislation, national guidelines, organisational policies and protocols in accordance with clinical/corporate governance which affect your work practice in relation to the assessment of bladder and bowel dysfunction
2. the importance of working within your sphere of competence and when to seek advice if faced with situations outside of your sphere of competence
3. the importance of applying standard precautions for infection control and the potential consequences of poor practice
4. the importance of documentation, the data protection act, care of records and disclosure of information with consent from the individual and your employer and the legal and professional consequences of poor practice
5. the anatomy and physiology of the male and female lower urinary tract in relation to lower urinary tract function and continence status including:
  1. urine production and what influences this
  2. normal micturition
  3. the nervous system, including autonomic dysreflexia
  4. the bowel
  5. the pelvic floor muscles/complex
  6. the endocrine system
  7. the prostate
  8. reflexes
6. the anatomy and physiology of the male and female lower gastro intestinal tract in relation to lower bowel function and continence status including:
  1. stool production and what influences this
  2. normal defaecation
  3. the nervous system including autonomic dysreflexia

- 4.the bowel
- 5.the pelvic floor/complex and anal sphincter muscles
- 6.the endocrine system
- 7.reflexes
- 7.the specific health conditions which may have an impact on bladder and bowel function including continence status
- 8.the different classifications and types of bladder and bowel dysfunction
- 9.the aspects of individuals' and their families' past medical history which may be relevant to the assessment and diagnosis
- 10.the impact of pregnancy and childbirth on bladder and bowel function including continence status
- 11.the patho-physiological effects of certain conditions on bladder and bowel dysfunction
- 12.the types of continence assessment that are relevant to your area of practice
- 13.how to adapt continence assessment to the health status of the individual for example, end of life care, chronic long term conditions, post childbirth, infective diarrhoea, chronic urinary retention, disability
- 14.the importance of including risk assessment within the wider assessment process to identify high risk individuals with potentially life shortening conditions such as bowel/bladder cancer, systemic infection, skin breakdown because of incontinence
- 15.how bladder and bowel charts/questionnaires are used as an investigation to influence a diagnosis for individuals with bladder and bowel dysfunction
- 16.the relevant baseline observations and tests, including why they are required, how and when to perform them and the possibility of false results
- 17.of how to interpret and act on the findings of baseline observations, tests and clinical examination of individuals with bladder and/or bowel dysfunction
- 18.the further investigations and interventions that may be required for bladder and bowel dysfunction
- 19.the interpretation of results from further investigations and how they inform a diagnosis for individuals with bladder and/or bowel dysfunction
- 20.how certain categories of medication affect lower urinary tract and bowel function including continence status
- 21.how individuals current medication may affect their lower urinary tract and bowel symptoms including continence status
- 22.how lifestyle, diet and fluids affect bladder and bowel function
- 23.how to obtain valid consent, that the individual has the capacity to consent and cooperate and how to confirm that sufficient information has been provided on which to base this judgement
- 24.the those who may accompany the individual (e.g. carers, chaperones) and be present during the assessment and how to work with them
- 25.the importance of respecting individuals' privacy, dignity, wishes and beliefs and how to do so
- 26.the importance of minimising any unnecessary discomfort, and how to do so
- 27.when not to proceed or abandon an assessment and examination for an individual

## PERFORMANCE CRITERIA

You must be able to do the following:

- 1.apply standard precautions for infection prevention and control and take other appropriate health and safety measures
- 2.explain the assessment (including examination and tests) and obtain the necessary valid consent
- 3.respect the individual's privacy, dignity, wishes and beliefs, and seek to minimise embarrassment during the assessment
- 4.ensure that the environment and equipment are clean and suitable for the assessment
- 5.seek to reduce any communication barriers with the individual and relevant others by appropriately adapting communication methods
- 6.ask the individual to explain their bladder and/or bowel condition and its history in their own words or obtain the history from any relevant person accompanying the individual
- 7.obtain a list of the individual's medication, the clinical rationale for use and the impact on bladder and/or bowel activity and associated symptoms
- 8.assess the impact of bladder and/or bowel dysfunction on the individual's lifestyle, relationships and quality of life
- 9.carry out and interpret baseline observations and tests, where necessary, to support the assessment and aid a differential diagnosis
- 10.review, interpret and acknowledge charts and questionnaires to inform the assessment
- 11.carry out and interpret a systematic clinical examination as required
- 12.discuss with the individual and where necessary, any relevant person accompanying the individual, the
  - 1.findings of the assessment
  - 2.the likely causes of the symptoms
  - 3.the implications (prognosis) of the condition
  - 4.the risks identified
  - 5.your conclusion and differential diagnosis
  - 6.the need for any further investigations
- 13.initiate further investigations and onward referral as appropriate to the individual's condition
- 14.provide the individual with relevant information and advice related to their condition and any further investigations
- 15.make a full, accurate and clear record of the assessment and any agreed follow-up action

## **ADDITIONAL INFORMATION**

This National Occupational Standard was developed by Skills for Health in partnership with the Royal College of Nursing in December 2007. This standard links with the following dimension within the NHS Knowledge and Skills Framework (October 2004): Dimension: HWB6 Assessment and treatment planning