REHABILITATION STANDARD:  
BOWEL AND BLADDER MANAGEMENT

Residents of Vancouver Island Health Authority (VIHA) will have reasonable access to consistent, integrated, measurable, evidence based rehabilitation services. This will be achieved through the use of standards that describe the baseline for rehabilitation services that an individual can expect to receive in VIHA.

This care standard outlines the process for assessment and management of bowel and bladder function. The rehabilitation goal is to ensure that the individual is provided with an appropriate care to manage their bowel and bladder.

Criteria for Referral
Individuals experiencing the following risk factors should be assessed by a healthcare provider:

- Impaired mobility
- Bowel dysfunction
- Chronic illness
- Interstitial cystitis
- Cognitive impairment
- Psychological dysfunction
- Stroke
- Bowel or bladder incontinence
- Complicated bowel/bladder management routines
- Psychological dysfunction
- Paralytic ileus
- Neurogenic bowel or bladder dysfunction
- Colostomy, Ileostomy, Koch Pouch

The healthcare provider must obtain informed consent from the individual prior to the initiation of any assessment and intervention.

Screen
Any member of the multidisciplinary healthcare team can complete a screen of bowel and bladder function. Individuals identified with bowel or bladder problems should be referred for an assessment and treatment/intervention. Screening should take place within the first 24 hours of admission to a hospital/facility and within 1 to 3 days or within the first 3 visits for admission to community care.

A bowel and bladder screen should include:

- Admission history and/or checklist to identify risk factors
- An assessment of daily bowel and bladder function

Constipation, poor function or incontinence indicates the need for assessment, diagnosis and plan of care that may include a nurse, dietician, occupational therapist, physiotherapist or physician.

If interventions based on the screening results exceed the healthcare provider’s expertise or knowledge, a referral for an assessment should be made at first contact and clearly documented.

Results of the screen including any recommendations will be documented in the individual's chart.
Assessment
An assessment should take place when additional expertise is required to address the bowel and/or bladder management needs of the individual.

An assessment for bowel care can be conducted by a nurse, care aide, dietician, occupational therapist, physiotherapist or physician and should include:
- Identification of risk factors and other contributing factors to bowel problems
- A physical exam or testing to rule out infection or disease
- Review of medications

An assessment for bladder care can be conducted by a nurse, care aide, occupational therapist, physiotherapist or physician and should include:
- Identification of symptoms such as stress, urge, mixed, overflow and functional incontinence
- Identification of risk factors and other contributing factors
- A physical exam or testing to rule out infection or disease
- Review of medications

Plan
In collaboration with the individual and caregivers the healthcare provider will establish a plan for addressing the management of bowel and bladder function. Interventions may include but are not limited to the following:
- Provision of education for individual and/or family
- Development of a plan with the individual and/or family
- Documentation of effectiveness of the plan and any problems identified
- Reassessment and revision of the plan as required or when there is a change in bowel or bladder function

The expected outcomes are:
- The individual will achieve regular bowel movements on a regular time schedule.
- The individual will achieve consistent bladder emptying safely and effectively.

Documentation
The multidisciplinary healthcare team is responsible for documenting the results of assessments, treatment plans and ongoing progress notes regarding the individual’s equipment needs. This documentation should be kept in a manner that is accessible to all members of the team using communication tools such as the cardex, care plan, ADL card, or information booklet.

Evaluation
The indicators used to evaluate this standard include outcome indicators based on the expected outcomes and process indicators.

If any component of treatment is to be delegated, the individual will be informed.