Bladder & Bowel UK

Children's Rectal Irrigation Pathway

National guidance and clinical decision support tool for specialist healthcare professionals managing children and young people with bowel dysfunction

Version 2

Date of publication: February 2024

Date review due: January 2027

Document Purpose	National guidance and clinical decision support tool for best practice
Document name	Children's Rectal Irrigation Pathway National guidance and clinical decision support tool for specialist healthcare professionals managing children and young people with bowel dysfunction
Publication date	Version 2: February 2024
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Target Audience	Integrated Care Board's Children's Leads, Health Board Clinical Leads, Health and Social Care Board Clinical Leads, Primary Care Network Clinical Leads, NHS Foundation Trust CE's, NHS Trust CE's, Directors of Nursing, Local Authority CE's, NHS Trust Boards, Paediatric Gastroenterologists, Paediatricians, Paediatric Surgeons, GPs, Directors of Children's Services, Children's Bladder and Bowel Service Leads, Children's Bladder and Bowel Specialist Nurses, Stoma Nurses
Additional Circulation List	Adult Bladder and Bowel Services
Cross Reference	Adult Irrigation Pathway
Description	Consensus, peer reviewed guidance and clinical decision support tool providing a pathway and supporting documentation for teaching and using rectal irrigation in children and young people up to the age of 18 years old. The aim is to ensure equity of access to rectal irrigation and highest standards of professional care for children and young people across the UK who are being assessed for or are using this intervention.
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Review date	January 2027
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Disclaimer

This document is designed to support specialist healthcare professionals in the assessment for, instigation and review of children who may benefit from, or who are using rectal irrigation. This guidance and clinical decision support tool is based on current best practice and consensus and has been peer reviewed with the aim that access to this intervention and care when using it is consistent throughout the United Kingdom.

It is expected that the specialist healthcare professionals using this document exercise their expertise and judgement, in applying the general principles and recommendations contained within it. Recommendations may not be appropriate in all circumstances. The decision to adopt specific recommendations should be made by the specialist healthcare professional, considering the individual circumstances of each child or young person, their wishes (accounting for their understanding and ability to consent) and that of the person(s) with parental responsibility, their environment and the available resources.

This documentation, if used, should be stored in the child's medical records, in line with organisational policy.

All references to children or child in this document refer to any child or young person up to their 18th birthday.

Introduction

The pooled prevalence of chronic constipation for all children worldwide is 9.5% (Koppen et al 2018), and children with autism or learning disabilities are disproportionately affected with a median prevalence of 22% (Maslen et al 2022). Constipation is considered to be a multifactorial condition that is associated with faecal incontinence, shame, stigma, impaired school attendance, attainment and experiences, and poor quality of life for the child and family.

For most children constipation is functional and can be effectively treated, as per NICE guidance and NHS England Pathway (2023), with laxatives, lifestyle interventions and toileting advice, although NICE notes that: 'By the time the child or young person is seen they may be in a vicious cycle'. Children and young people and their families are often given conflicting advice and practice is inconsistent, making treatment potentially less effective and frustrating for all concerned.' (NICE 2010).

For a proportion of children functional constipation is intractable: it does not respond to optimum medical management and a significant minority have constipation associated with congenital malformations, Hirschsprung's disease or spinal nerve damage resulting in neuropathic bowels. Many of these children continue to have faecal incontinence when treated with conventional options alone.

Rectal irrigation was introduced in1987 for managing fecal incontinence associated with constipation, in children with neurogenic bowel dysfunction (Caponcelli et al 2021). Irrigation has evolved with a wide choice of specialised equipment and evidence for improving constipation, faecal incontinence, quality of life, and independence. A systematic review of 27 studies involving 1040 children (average age 8 years), showed an average success rate of 78-84% for relief of symptoms and improved bowel control and 86- 95% improved quality of life when rectal irrigation was used (Mosiello et al 2017).

Anecdotal evidence suggests that the adoption, availability of and approach to rectal irrigation in children varies across the United Kingdom. This guidance document, which is based on evidence and consensus of best practice and has been subject to extensive peer review, aims to standardise the approach to rectal irrigation for all children and young people throughout the UK.

References

Caponcelli E (2021) Transanal irrigation in the paediatric population: literature review and consensus of an Italian multicentre working group Medical and Surgical Pediatrics 2021 45:250

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NHS England (2023) National primary care clinical pathway for constipation in children https://www.england.nhs.uk/publication/national-primary-care-clinical-pathway-for-constipation-in-children/ Accessed 10.8.2023

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Reviewers

This document has been subject to extensive peer review. The authors are grateful for all their contributions. Reviewers include specialist children's bladder and bowel nurses working in the community and in surgical centres and paediatricians from across the UK. The following have agreed to have their details included as reviewers:

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Acknowledgements and declarations of interest

This document has been adapted from the rectal irrigation pathway produced by the Northern Children's Transanal Irrigation Focus Group (2021), which was inspired by the Adult Transanal Irrigation Pathway, produced by the Northern Irrigation Professional Group June 2018*. Both of the groups that produced these documents were facilitated by B. Braun Medical Ltd.

Thanks are also extended to Michelle Henderson RGN, Clinical Education Manager, Qufora UK (and previously Lead Nurse, Durham Bowel Service), to B. Braun Medical Ltd and to Qufora UK for supporting development of this document.

The companies were not involved in the design, writing or peer review of this pathway or its supporting documentation.

*B Braun Medical. Adult transanal irrigation (TAI) pathway. 2018. www.bbraun.co.uk/en/company/contact.html

Children's Rectal Irrigation Pathway

BACKGROUND INFORMATION: This document is for specialist healthcare professionals managing children / young people with bowel dysfunction

Referred to specialist service for bowel dysfunction management

When would you consider rectal irrigation?

Following bowel assessment patient diagnosed with neuropathic bowel, chronic constipation and / or faecal incontinence, due to any underlying cause, with one or more of the following:

- Inadequate response to laxative therapies
- Inadequate tolerance of laxative therapies
- Inadequate response to adjustments to toileting routines and positions
- Inadequate response to adjustments to diet and lifestyle changes in combination with other interventions
- Symptoms continuing to affect wellbeing, schooling and social life despite specialist service intervention

What are the Contraindications and Cautions for rectal irrigation?

Contraindications: if any apply do not commence irrigation
Carer/child does not accept this form of treatment
Anal or colorectal stenosis
Rectal or colorectal surgery within last six months
Active inflammatory bowel disease (IBD)
Ischemic colitis
During chemotherapy

Cautions: tick those that apply and discuss with MDT
Physical impairment of child or carer
Cognitive impairment of carer
Underlying mental health issues where system could be used inappropriately by child or carer
Safeguarding concerns
Faecal impaction (disimpact first, or commence after passage of large bowel motion)
Use of any rectal medication for other medical conditions (irrigation may dilute/remove the medication)
Rectal prolapse
Anal abnormality
Painful anal conditions e.g. painful fissure
Previous anal, colorectal or pelvic surgery or radiotherapy to pelvic or abdominal area
Conditions where fluid balance is critically important e.g. renal or liver disease (consider use of saline and monitoring electrolytes)
Prone to rectal bleeding or on anticoagulant therapy
Children younger than 3 years old

What should be done before child commences rectal irrigation?

- Discuss rectal irrigation with lead medical professional, or refer to paediatrician (according to local policy)
- Complete Rectal Irrigation Assessment Form, including Bothersome Questionnaire and:
  - Consider availability of carers to assist with irrigation as required/appropriate to child's needs
  - Consider child and carers dexterity, mobility and stability on the toilet or suitable alternative
  - Consider home environment, and any adaptations that may be required
  - Explain procedure, discuss benefits and risks, provide literature and signpost to relevant website(s)

Introducing rectal irrigation to the child and their carer

- Product choice will depend on individual circumstances and volume of water to be used:
  - Consider use of cone if child /carer has good dexterity with ability to hold cone in place, ability to operate the system, and if the child has good balance and stability on toilet
  - Consider use of catheter if the child has low anal tone, poor balance on toilet, and if child / carer has poor dexterity
  - Consider amount of water to be used and whether low or high volume system is more appropriate to the individual
- Consider the need to introduce irrigation and the equipment gradually to the child and family:
  - Provide time and opportunity for the child and family to see / play and familiarise themselves with the device (preferably at home) before irrigation attempted (may take more than one visit)
  - Consider involving play therapist or psychologist if child is struggling to accept rectal irrigation
- Set guidelines for the child/family about volume of water to be used initially (usual guide is to work towards 10 – 20mls/kg)
- Advise the child/family to use irrigation daily at a time that works for them and maintain a bowel / irrigation diary
- Specialist nurse support required for at least first irrigation (initial irrigation at home if possible) and provide appointment for first review and contact details in case of questions / concerns

Next steps:

- Write to GP and other professionals as appropriate, to inform them that the child has been started on rectal irrigation
- Enclose copy of irrigation guidelines for the GP, if used locally
- Provide information to the GP about product codes, frequency of ordering and delivery service patient is registered with (if using)
- Set up delivery service if required

First review:

- The initial review should be undertaken within 24 – 48 hours of the child commencing rectal irrigation:
  - Review technical ability, results, confirm water volume, check child / carer happy to continue
  - Advise the child/family about how much water to use (usual guide is to work towards 10-20mls/kg) and how to adjust according to tolerance, results and engagement with the procedure
  - Ensure the family have specialist service contact details and information about how to respond to urgent concerns

Further reviews:

- Undertake further reviews according to individual needs
- Discuss:
  - effectiveness (include frequency of use, volume of water and timing of procedure)
  - adherence
  - technical ability, including how they are managing equipment
  - who is supporting the child / young person
  - what the child is managing themselves, how can independence be promoted if appropriate
  - any issues with equipment, timely order requests and delivery
  - any ongoing oral laxative use
  - ongoing treatment plan
- Adjust laxative and irrigation use if required
- Discuss weaning of laxatives with the child and family as appropriate
- Discuss weaning of irrigation with the child and family as appropriate
- Continue to update GP with details of progress and prescription at least annually
- Ensure family still have specialist service contact details for concerns and who to contact out of hours for urgent issues
- Start work on transition plan for all children and young people from age 12 if any likelihood of rectal irrigation continuing beyond 18th birthday in line with local and national polices, procedures and guidelines

If irrigation results in:

Improving bowel symptoms

- Review as required for continued support (minimum annually)
- Ensure family have contact details for specialist nurse team
- Add child to local rectal irrigation database, if available

No improvement in bowel symptoms

- Consider referral for further investigations and alternative treatment pathway

Discontinuation

- Inform GP and medical team that child has discontinued irrigation with reason why
- Remove child from local irrigation database with reason for discontinuing

Weaning irrigation

If irrigation is successful children should continue to use it in line with the pathway. Some children with chronic functional constipation, may be successfully weaned off irrigation as their symptoms resolve. For children with neuropathic bowel and for some with non-idiopathic constipation weaning may not be appropriate.

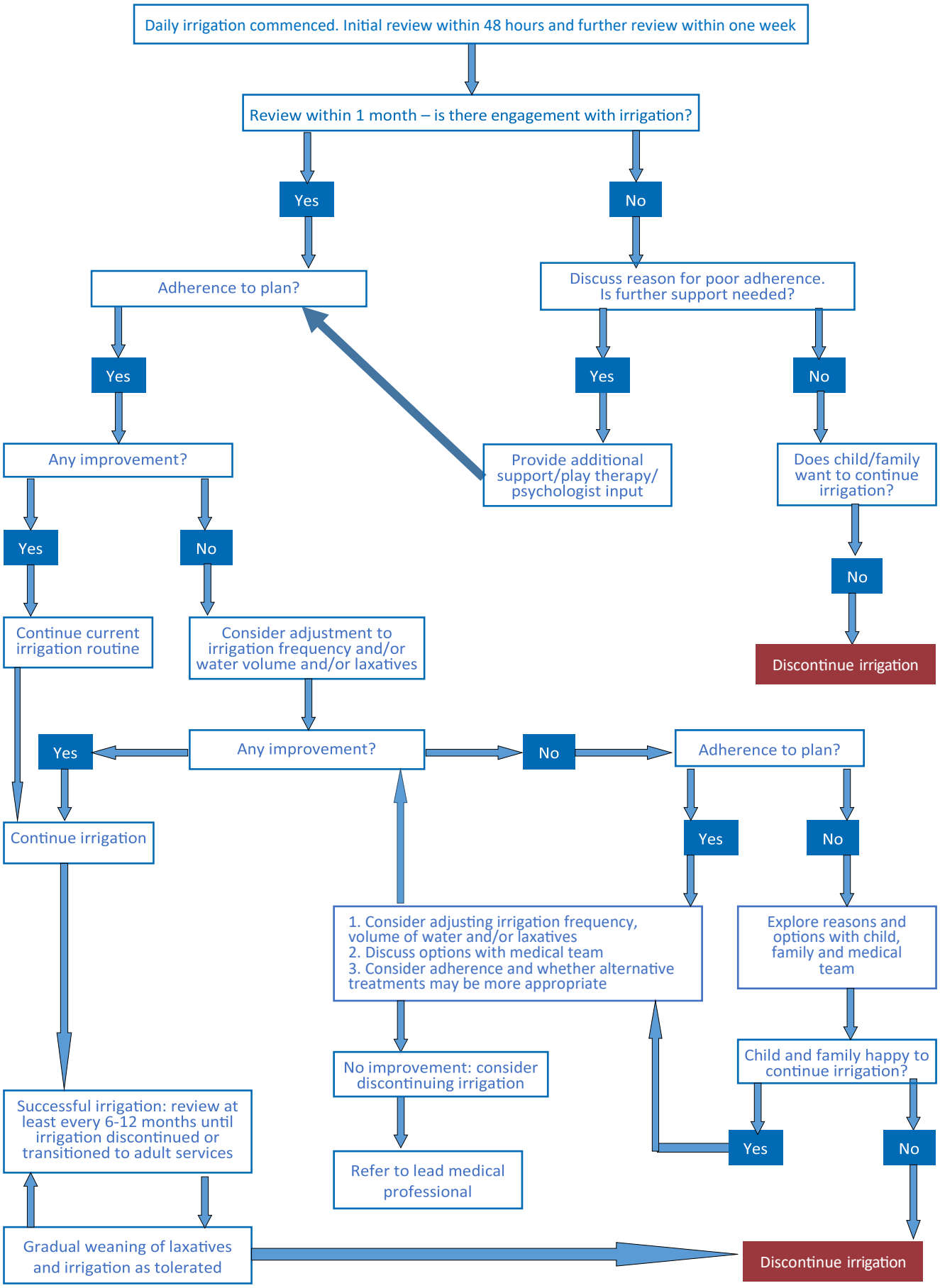
How to wean:

Should there be no soiling for 6—8 weeks and the child is opening their bowels independently at times and not just post irrigation, the irrigation may be reduced by one day a week. If progress is maintained over the next 6 –8 weeks irrigation may be reduced by a further day a week, but at a different time of the week to the previous reduction (e.g. omit on a Wednesday and Saturday). If there is relapse in symptoms reassessment should be undertaken and treatment readjusted accordingly.

If the child continues to be clean and have independent bowel movements irrigation may be reduced further every 6—8 weeks until it is discontinued.

NB. As bowel symptoms improve consideration should be given to whether laxatives should be gradually reduced. Some children may require ongoing oral laxatives in addition to using rectal irrigation.

Rectal Irrigation Pathway for Children



Initial Assessment for Rectal Irrigation in Children

The personal data provided on this form is for patient care record purposes only and will be stored in accordance with the NHS Trust Privacy Policy.

Name of child		Consultation Date	
DOB		Consultant/GP	
NHS/Unit No		Hospital (if applicable)	
Reason for irrigation			
Diagnosis			
Allergies		Weight	

Consent to rectal irrigation? Yes ☐ No ☐

Completed bothersomeness questionnaire? Yes ☐ No ☐

Contraindications: if any apply do not commence irrigation		Cautions: tick those that apply and discuss with MDT (see box below)	
Carer/child does not accept this form of treatment		Underlying mental health issues where system could be used inappropriately by child or carer	
Anal or colorectal stenosis		Safeguarding concerns	
Rectal or colorectal surgery within last six months		Faecal impaction (disimpact first, or commence after passage of large bowel motion)	
Active inflammatory bowel disease (IBD)		Use of any rectal medication for other medical conditions (irrigation may dilute/remove the medication)	
Ischemic colitis		Rectal prolapse	
During chemotherapy		Anal abnormality	
		Painful anal condition e.g. anal fissure	
		Previous anal, colorectal or pelvic surgery or radiotherapy to pelvic or abdominal area	
		Conditions where fluid balance is critically important e.g. renal or liver disease (consider use of saline and monitoring electrolytes)	
		Prone to rectal bleeding or on anticoagulant therapy	
		Child younger than 3 years old	

If cautions are present, discussed with MDT?	**Yes**	**No**
Outcome of MDT discussion or reason why discussion not taken place:		

SIGNED:		TITLE:		DATE:	

Reasons for commencing rectal irrigation (tick all those that apply)

Inadequate response to or tolerance of oral laxatives and/or suppositories	☐
Inadequate response to adjustments to toileting routines and positions	☐
Inadequate response to adjustments to diet and lifestyle changes in combination with other interventions	☐
Symptoms continuing to affect wellbeing, schooling and social life despite specialist service intervention	☐

Teaching rectal irrigation (tick when carried out and document dates and details of discussions in medical records)

Discussed benefits of rectal irrigation (how and why it works)	☐
Discussed risks of rectal irrigation (side- effects including perforation, discomfort, abdominal cramps etc)	☐
Equipment choices discussed (cone or catheter, high or low volume) and decision made about which equipment to use	☐
Verbal instructions about how to use specific irrigation system (refer to manufacturer's instructions)	☐
Demonstration of rectal irrigation equipment carried out (ensure child / family plays with / handles equipment under supervision from HCP and / or play therapist or psychologist if difficulty with engagement)	☐
Literature / information given / signposted to website provided by company	☐
Regime discussed: volume of water to be used initially and how much it may be gradually increased to (min and max volumes: usually 10—20mls/kg), frequency of irrigation, and appropriate time of day for use	☐
Child and / or carer supported with initial rectal irrigation by healthcare professional	☐
Discussed when and how to seek medical intervention if any concerns or any side-effects e.g. rectal bleeding	☐
Ask child / young person or family to complete a diary of irrigation until stable and for two weeks prior to reviews	☐

Specialist professional who initiated irrigation:	
Prescription letter sent to GP / Central Prescription Service?	Yes No
Name of irrigation equipment prescribed:	
Product codes:	
Frequency of rectal irrigation	Daily ☐ Alternate days ☐ Other (specify):
Volume of water prescribed (usually 10 –20mls per kg)	

Delivery/Collection Information:

Option chosen: (include contact details)	Dispensing Appliance Contractor (DAC):	
	Local Chemist:	
Frequency of order:		

- I/we have been informed of the benefits and risks associated with rectal irrigation.
- I/we understand how to use this equipment, when to use it and have been informed how much water to use .
- I/we would like to proceed with this treatment.

Parent / Carer Name		Parent / Carer Signature		date
Child Name (if appropriate)		Child Signature (if appropriate)		date
Specialist Nurse Name		Specialist Nurse Signature		date
Specialist Nurse contact details				

Review of Rectal Irrigation in Children

The personal data provided on this form is for patient care record purposes only and will be stored in accordance with the NHS Trust Privacy Policy.

Name of child		DOB		NHS No	
Specialist professional who initiated rectal irrigation				Date	
Laxatives / medication prescribed					
Name of irrigation system prescribed					
Prescribed regime					
GP / Consultant					

REVIEW (If No, complete action and write in comments)			ACTION PLAN	COMMENTS For further information
Has irrigation been problem free? E.g. consider bleeding, abdominal cramps, discomfort, dizziness or light-headedness	YES	NO	If bleeding (more than would cover a £2 coin) has occurred refer urgently to medical team If pain has occurred explore if this is the child learning a typical sensation to poo, or if it is acute pain that requires medical investigation Explore side effects, possible technical difficulties and ensure that the child has appropriate support when irrigating Adjust procedure as appropriate e.g ensure lubrication of catheter / cone, confirm volume of water entering the rectum, adjust speed of administration of water, confirm water at body temperature, liaise with medical team if pain continues for more than a few minutes after bowel movement	
Is the child or young person starting to engage with irrigation?	YES	NO	Assess if irrigation is being used as prescribed. Explore reasons if not and provide support and guidance as appropriate	
Are they achieving a soft bowel motion each time and then experiencing a period without soiling?	YES	NO	Assess how often irrigation is used (may need to be less if passing water only, or more if soiling occurring) Assess volume of water used (10—20mls/kg is usual guide, some children may require more or less)	
Is the period without soiling extending or are they clean between irrigations?	YES	NO	Assess toileting position. Ensure child has appropriate toileting aids e.g. reducer seat, foot stool, handles, specialist aids Assess how much time is spent on the toilet. Usual is to start with 10-15mins and adjust as appropriate. Assess frequency and timing of toileting. Suggest 30 minutes after a meal to work with gastro-colic reflex Recommend techniques to be carried out during toileting to encourage effective evacuation (e.g. blowing, rocking, abdominal massage etc.) Review laxatives and adjust as appropriate	
Have symptoms improved?	YES	NO	Discuss frequency/timing of irrigation e.g. 30 minutes after a meal - to work with gastro-colic reflex Encourage to persevere for an initial 6—12 weeks. Consider strategies to increase engagement if required. Consider changing irrigation system or treatment if still no improvement Is irrigation system most appropriate for child and symptoms? (Consider changing depending on the volume of water required—if changed review and assess effectiveness within one month)	

SIGNED		TITLE:		DATE:	

Is cone/catheter and water inserted without any difficulties?	Yes	No	Consider whether there may be faecal impaction Observe / discuss body positioning and insertion technique Assess for development of anal fissures Is irrigation system most appropriate for the child and symptoms? (Consider changing to cone / catheter system—if changed review and assess effectiveness within one month)	
Is the child adhering to oral laxative medication plan (if oral medication is prescribed), toileting, diet and fluid advice?	Yes	No	Discuss reasons for non-adherence. Offer guidance and support to promote adherence Review within one month to assess progress	
Has the child been performing rectal irrigation independently?	Yes	No	Assess whether a different rectal irrigation system may be more appropriate to promote independence Assess if independent toileting is appropriate for the child at present or in the future	
Has the child or family kept a diary of rectal irrigation?	Yes	No	Provide diary to family and request recording of use and outcome of irrigation for 2 weeks before next review to aid reassessment	
Has the child received an appointment for next review?	Yes	No	Arrange a further appointment in accordance with individual need and local policy Monthly / 3 monthly / 6 monthly / annual	
Does the child and family continue to be motivated and consent to continue to carry out irrigation?	Yes	No	If motivation to continue is low, discuss reasons and assess if able to continue Consider referring to play therapist / psychologist Discuss next steps with MDT	
Do the family still have full details of who to contact if any problems occur with rectal irrigation between reviews?	Yes	No	Ensure the family have correct contact details for: Prescriber Supplier of equipment Specialist team Appropriate other team members	

Additional Information

Travel advice, to discuss if needed

- Discuss possible changes to bowel habits due to changes in diet / time / routines
- Use tap water that is safe to drink for irrigation, if not available use cooled boiled water / bottled water
- Discuss prescription requirements and order early (if necessary)
- Discuss any changes to equipment if needed
- Advise family to obtain clinical letter or request travel certificate from irrigation supplier about need for equipment if travelling abroad

Pregnancy advice, to discuss if needed

- Inform the young person the reason to discontinue use of irrigation immediately and not resume until review by their maternity healthcare professional
- Discontinue irrigation prescription immediately with GP and supplier and ask GP for urgent referral to obstetrics
- Do urgent referral to the midwife/obstetrician team to discuss irrigation and possible alternative options, if necessary

Specialist Nurse Name		Specialist Nurse Signature		Date
Specialist Nurse contact details				

Bothersomeness Questionnaire

This questionnaire helps measure the impact of your child's bowel issues and soiling during day-to-day activities. It does this by asking how bothersome the problem is. Bothersomeness is something that a person finds upsetting, annoying or worrying.

We are interested in learning more about the impact that the bowel issues are having for you and your child and would value your time in completing this questionnaire. There are no right or wrong answers. The information you provide will be kept confidential but will help us to understand how helpful rectal irrigation is for you and your child.

Name of child		Consultation Date	
DOB		NHS/Unit No	
Name of parent/carer completing form			
Date of completion			

Parent/carer perspective. To be completed by parent or carer:	Score
1. Do you worry about your child going to social activities, including sleepovers due to their bowel issues? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
2. Do you worry about your child going to school / after school activities due to their bowel issues? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
3. Do you worry about your child's friendships / bullying at school because of their bowel issues? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
4. Do you worry about your child taking part in family activities / days out due to their bowel issues? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
5. How much do you think the bowel issues bother your child, daily / weekly? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
6. Do you worry about the impact of your child's bowel issues on your household finances? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
7. Do you worry about your child's motivation to follow advice and gain complete bowel control? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
8. How much do your child's bowel issues impact on the quality of life for you and the rest of the family that live with you? 0 - Not at all 1 - A little bit 2 - Some 3 - Quite a bit 4 - A lot	
Total:	
Additional comments:	

Name of child		Consultation Date	
DOB		NHS/Unit No	

Child's perspective. To be completed by child	Score
1. Do you worry about going to social activities, including sleepovers due to your bowel issues? 0 - Not at all  1 - A little bit  2 - Some  3 - Quite a bit  4 - A lot 	
2. Do you worry about going to school / after school activities due to your bowel issues? 0 - Not at all  1 - A little bit  2 - Some  3 - Quite a bit  4 - A lot 	
3. Do you worry about friendships at school because of your bowel issues? 0 - Not at all  1 - A little bit  2 - Some  3 - Quite a bit  4 - A lot 	
4. Do you worry about taking part in family activities / days out due your bowel issues? 0 - Not at all  1 - A little bit  2 - Some  3 - Quite a bit  4 - A lot 	
5. How much do your bowel issues bother you? 0 - Not at all  1 - A little bit  2 - Some  3 - Quite a bit  4 - A lot 	
Total:	

Is there anything else you want us to know?

You can use this space to draw a picture or write down anything that you think is going well, or that is worrying you.

Specialist Nurse Name		Specialist Nurse Signature		Date
Specialist nurse contact details				
Carer Name		Carer Signature		Date
Child Name (if appropriate)		Child Signature (if appropriate)		Date

Name of child		Consultation Date	
DOB		NHS/Unit No	

Care plan / evaluation *(Include any changes to plan or other relevant information)*	

Specialist Nurse Name		Specialist Nurse Signature		Date
Specialist nurse contact details				

Bowel / Irrigation Diary

DATE	TIME	STOOL TYPE (use Bristol Stool Chart)	AMOUNT PASSED (small, medium, large)	IRRIGATION (volume of water used)	LAXATIVES	OTHER e.g blood or mucous with stools, abdominal pain, or other symptoms

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Version 2

Date of publication: February 2024

Date review due: January 2027