CLINICAL RESOURCE ADVANTAGE
RIGHT PATIENT, RIGHT PRODUCT, RIGHT RESULT

Fecal Incontinence Patient Selection Assessment Table

FI Assessment Parameters	Assessment Criteria		
Patient History and Physical Assessment	• Determine underlying type and cause of fecal incontinence • Evaluate potential cause(s) of fecal incontinence and associated complications • Assess for medical conditions, contraindications and warnings to all interventions • Use appropriate Pain Scale or Assessment Tool to detect pain per facility policy		
Abdominal Assessment	• Assess abdomen for stool impaction, abnormalities and pain		
Rectal Assessment	• Assess fecal output for stool frequency, consistency and volume • Obtain stool culture if stool consistency is semi-liquid to liquid (diarrhea) or if ileus is suspected o If diarrhea present, initiate and document Contact Precautions until resolved • Conduct digital rectal exam to determine rectal tone, sensation, abnormalities and to detect stool impaction o If stool impaction, disimpact per facility policy		
Skin Assessment	• Assess skin for injury, abnormalities and dehydration		
Risk Parameters	**Risk Levels for Developing complications Associated with FI**		
	At Risk	**Moderate Risk**	**High Risk**
Stool Frequency	< 3 stools in 24 hrs	3 – 6 stools in 24 hrs	> 6 stools in 24 hrs
Stool Consistency	Solid to Semi-Solid	Semi-Solid to Semi-Liquid	Semi-Liquid to Liquid
Bristol Stool Form Scale Score	Type 1 – 4 Hard (impacted) to Normal	Type 4 – 6 Normal to Loose stool	Type 6 – 7 Loose stool to diarrhea
Stool Culture	Negative	Negative/Positive	Positive
Braden Scale Score	18 – 15	14 – 13	12 or <
IAD Risk Level	No Risk Skin intact	High Risk to Early IAD Skin intact, Erythema, No Blisters	Moderate to Severe IAD Skin NOT Intact