Brief Methodological Report

Implementation of the Victoria Bowel Performance Scale

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Abstract

Context. There is a lack of evidence to guide constipation management in patients receiving palliative care. Data collection requires the systematic use of validated assessment tools.

Objectives. The objective of this study was to assess the usefulness of the Victoria Bowel Performance Scale (BPS) as an audit tool.

Methods. Charts were reviewed before and after the implementation of a program to monitor constipation through repeated use of the Victoria Bowel Scale. The program was initiated at three oncology pain and symptom management clinics, four palliative care units, and four residential hospices. An additional "control" palliative care unit introduced new nursing assessment tools without the new scale.

Results. The Victoria BPS was recorded at 86% of 192 postimplementation outpatient clinic visits and was easy to use in this setting. Documentation of bowel performance at comparable visits improved from 44% to 66% ($P < 0.001$), and the frequency of changes to laxatives increased from 14% to 39% of visits ($P < 0.001$). The scale was completed on 21%–55% of inpatient days, and variations in the proportion of recordings being rated as satisfactory between −1 and +1 (possible range from −4 to +4) revealed important deficiencies in bowel care, which led to change in management.

Conclusion. The Victoria BPS was found to be an acceptable and a useful bowel function assessment tool, uniquely incorporating the patient's usual bowel function. Modifications to the scale have been made to improve clarity and allow for the expected drop in bowel activity seen in end-of-life care. Considerable educational effort and appropriate organization of the charts are required for optimal implementation. The proportion of revised BPS scores ranging from −1 to +1 is proposed as an indicator of satisfactory bowel management for clinical, audit, and research purposes. J Pain Symptom Manage 2011;42:946–953.

Key Words

Constipation, nursing assessment, palliative care, hospice, laxatives

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Introduction

Constipation is an extremely common complication of many advanced diseases, such as cancer, heart failure, and chronic lung diseases.[1] Constipation can be exacerbated by medications commonly used for symptom control in patients with advanced disease, especially the use of opioids.[2] There is very little evidence available to guide bowel care, and research is urgently needed to be able to develop evidence-based treatment recommendations.[2–7]

Most clinical research on constipation relies on outcome assessments based on arbitrary definitions of constipation,[8] which may not be useful at the end of life when expectations for bowel function are quite different from when one is healthy. No assessment tools have yet been evaluated in the palliative care setting, and currently available constipation assessment tools[9–11] are too time consuming for routine use, require too much patient participation to be applied with patients near end of life, do not take into consideration the wide variation in "normal" bowel function, or are not detailed enough to provide sufficient information with which to assess the adequacy of constipation management.[12] A simple severity scale may rate a patient as having severe constipation if they require daily laxatives, even if the problem no longer causes any distress to the patient because the laxatives are effective. To avoid under- or overdosing of laxatives, a better system for grading the severity of constipation is needed when tailoring laxative treatment to the individual.

The Victoria Bowel Performance Scale (BPS)[13] is a new 9-point numerical scale designed for the palliative care setting. The scale integrates reporting of stool frequency, consistency, and ease of passing into a single score. Studies are needed to evaluate the use of this tool in practice.

Methods

Outpatient oncology pain and symptom management/palliative care clinics, general hospital palliative care units (PCUs), and residential hospices that were easily accessible from Vancouver, British Columbia, were approached by the study team to assess willingness to participate in this study, until there were four sites recruited in each of the three setting types; a total of 12 participating sites. Sites were visited by one of the authors, and (where possible) one of the two chart reviewers, who were students completing a premedical undergraduate degree at the University of British Columbia. Each site's constipation management and bowel movement charting processes were identified, and the nursing leader was interviewed. All nursing, medical, and pharmacy staff at each site were invited to complete a short survey about their site's bowel care and were made aware that the charts of their current patients may be reviewed at some point in the future and the BPS would be introduced once the modified documents had been developed.

In the cancer center outpatient clinics, an area to mark the BPS score and list current laxatives was added to a comprehensive symptom and palliative care needs/outcomes assessment tool that was already in routine use at one of the three clinics. This tool included the Palliative Performance Scale,[14] the Palliative Outcomes Scale,[15] a modified Edmonton Symptom Assessment System scale,[16] body map, and a single-item quality-of-life scale.[17] All outpatient sites used this modified assessment tool throughout the postimplementation phase of the study.

At the inpatient sites, the BPS was incorporated into either a new bowel "flow sheet" or a medication administration record. Orientation to the BPS was provided at each site to the nurse educator, clinical nurse leader, or most senior nurse (hereon referred to as "trained local staff") by one of the three members of the study team, and at least one training session was provided for the nurses, with the aim of all nurses participating in one session, repeat training sessions allowing for different shifts. Thereafter, nurse training was continued by the trained local staff only.

Two sets of 30 patient charts were requested for review at each site; the first set was from patients cared for after recruitment to the study but *before* implementation of the BPS, and the second was from patients cared for *after* implementation of the BPS. Charts were selected by consecutive admission or first outpatient visit dating back from each chart request. The only exclusion criterion was for the PCU

and hospice patients having lengths of stay of less than five days.

Outcome assessment was required to be different between the outpatient and inpatient sites. At the outpatient clinics, the primary and secondary outcomes were the rates of documentation of bowel performance and/or advice on laxative therapy in the dictated physician note. In the inpatient sites (PCU and hospice), the primary outcome was planned to be the rate of documentation of bowel function in the chart, either by physician or nurse. No alterations were made in the sites' usual laxative orders ("bowel protocols") during the study.

To explore the possibility that any change following the addition of the BPS might be because of the extra attention drawn to charting, which accompanies need for change in practice and/or awareness of being part of a study, a fifth PCU was recruited as a "control" site because it was planning on introducing a new nursing charting process that did *not* include the BPS.

Preliminary analysis of results from all the outpatient visits showed that physician documentation of bowel habit and laxative treatment was higher at first visits than at follow-ups, and that the number of follow-ups differed between the pre-BPS and post-BPS patient chart sets (4.5 vs. 2.1 visits per patient). This would have introduced bias to the study, so to ensure that the data from the pre-BPS and post-BPS chart sets were comparable in all other respects, the outpatient data analyzed and presented here were, therefore, reduced to include only the first and second visits for each patient.

Results

After recruitment to the study, one of the four outpatient clinics was unable to implement the BPS because of staffing changes and so was dropped from the study. One of the recruited hospices was unexpectedly closed down, but another hospice in the same regional health authority was recruited in its place. In total, 180 outpatient charts from 487 clinic visits and 410 complete inpatient charts (7039 admitted days) were reviewed in detail. The outpatient groups were all cancer patients and were on average younger than the residential groups (50% vs. 65% older than 60 years). The residential sites included a small number of noncancer patients (<10%) in all but one of the PCUs (Site 4), where they formed 44% of the pre-BPS implementation patient chart set and 20% of the postimplementation chart set. The demographics (age, sex, and diagnostic categories) of the patients at each site did not differ otherwise. Detailed demographics are not included here in the interests of space but are available on request.

Outpatient Clinics

All outpatients had been referred for assistance with pain and symptom management and/or palliative care; most had advanced cancer. All tumor sites were represented, with a high proportion of breast, lung, gastrointestinal, and prostate primaries. The BPS was found to be easy to use in the clinic setting and acceptable to nurses and physicians. Compliance with documentation was good, with the BPS being completed at 86% of the post-BPS implementation patient visits.

Table 1
Outpatient Clinic Results

	Clinic 1		Clinic 2		Clinic 3		All Clinics Combined	
	Before	After	Before	After	Before	After	Before	After
Number of patients	20	29	23	15	20	16	**63**	**60**
Number of visits	40	58	46	30	40	32	**126**	**120**
BPS completed; % of visits	N/A	86	N/A	100	N/A	65	**N/A**	**84%**
Bowels mentioned in MD notes; % of 1st/2nd visits	50/50	64/46	43/22	86/67	70/30	81/67	**N/A**	**N/A**
Bowels mentioned in MD notes; % of total visits	50	55	33	77	50	75	**33%**	**69%**
Laxative change documented; % of 1st/2nd visits	30/20	46/36	9/9	67/20	15/15	44/38	**N/A**	**N/A**
Laxative change documented; % of total visits	25	41	9	43	15	32	**16%**	**39%**

As shown in Table 1, the impact of the new scale was striking. Physicians' documentation of bowel function increased from 33% to 69% of visits after implementation of the BPS, and the rate of laxative prescription increased from 16% to 39% of visits. Both these differences were highly statistically significant ($P < 0.001$).

Inpatient Palliative Care Units

Despite our initial attempts to compare bowel documentation in the pre-BPS and post-BPS patient chart sets, bowel documentation was extremely difficult to discern in the pre-BPS chart sets. The ward "kardex" was the primary communication tool between nurses, with the last bowel movement documented in pencil and repeatedly erased. Sometimes there was mention of bowel function in the nurses' narrative notes, but it was only very rarely found in the physicians' notes. Although there were indications of the patient having had a bowel movement some days in the nursing flowcharts, there was frequent discrepancy between the flowchart, nursing narrative, and the kardex. It was even rarer to find any comment in the pre-BPS charts regarding consistency of stool or ease of passage, and it was not possible to determine whether or not a patient's bowel performance was satisfactory in relation to desired or expected performance. In the post-BPS patient chart sets, the vast majority of the bowel charting was on the new BPS-specific records. The rate of BPS recording was, therefore, the only reliable way to retrospectively assess satisfaction with bowel function at any of the participating inpatient sites.

As shown in Table 2, the BPS revealed important differences in bowel care between participating units. BPS recording occurred on between 32% and 55% of admitted days, and the proportion of recordings in the range of −1 to +1 (indicating acceptable bowel performance) varied markedly, from only 31% of days at Site 5 to 80% at Site 4.

On discussion with nurses at Site 5, it was apparent that their standard bowel order, "laxative of choice," provided little guidance. An inadequate dose of laxative was usually initially dispensed, and when no bowel movement occurred for three days, a large dose was given, often causing diarrhea. In contrast, Site 4's stepwise bowel protocol provided specific guidance on escalating laxative doses.

At Site 6, a creditable 68% of recordings were between −1 and +1. Although this site did not have a standard ward bowel protocol, the attending physicians often wrote patient-specific instructions, and documentation of bowel habit on admission was high (80% in the pre-BPS patient chart set and improving to 90% in the post-BPS chart set). At Site 7, the medication administration record was used to record the scale instead of a flow sheet and their rate of BPS recording was 55% of days, the highest rate of all the inpatient sites.

At Site 8, the "control" site, a new nursing flowchart was introduced that had a bowel section but did not include the BPS (or Palliative Performance Scale). It was extremely difficult

Table 2
PCU Results

	Site 4		Site 5		Site 6		Site 7		Site 8	
	Before	After	Before	After	Before	After	Before	After	Before	After
Number of patients	18	30	30	29	30	30	24	26	17	12
Admitted days	271	411	651	593	328	352	229	382	243	189
Mean lengths of stay; days	15	14	22	20	11	12	10	15	14	16
BPS recorded; % of admitted days	N/A	54	N/A	32	N/A	32	N/A	55	N/A	N/A
BPS −1 to +1; % of all recordings	N/A	80	N/A	31	N/A	68	N/A	71	N/A	N/A
Bowel habit recorded on admission; % of patients	39	93	44	57	80	90	60	88	55	52
PPS recorded; % admitted days	N/A	69	N/A	39	N/A	92	N/A	86	N/A	N/A
≥1 Suppository; % of patients	27	40	47	37	7	17	33	38	31	44
≥1 Enema; % of patients	22	0	27	17	10	23	17	38	45	52
Suppository and/or enema on ≥1 day; % patients	44	40	50	43	17	33	45	56	47	50
Diarrhea on ≥1 day; % patients	17	69	73	80	10	22	8	62	18	19
Cramps on ≥1 day; % patients	4	4	30	33	30	33	17	23	35	19
Diarrhea and/or cramps on ≥1 day; % patients	22	77	80	87	24	53	64	72	47	50

to ascertain any information on satisfaction with bowel performance from these patient records, other than occurrence of a bowel movement and the laxatives dispensed, and there was no change in documentation quality between the pre- and post-change chart sets.

The rate of documented diarrhea varied markedly between sites, but was higher in the postimplementation groups. There was no association between rates of documented diarrhea and proportion of scale recordings being between −1 and +1. It is not possible to conclude whether the rate of diarrhea actually increased or whether use of the BPS triggered more frequent documentation, as the documentation was so poor in the pre-BPS chart sets.

The documentation of performance status varied between 39% and 92% of the days and was determined by prior familiarity with the Palliative Performance Scale.

Residential Hospices

At Site 10, 50% of the post-BPS chart set did not have cancer, as compared with 10%−20% noncancer diagnoses in all other hospice groups. The noncancer diagnoses were varied and often multiple, with no predominance of any one condition. The average ages of each residential hospice group were much the same (73−75 years) and older than at the PCUs. The proportion of patients of each gender was almost equal at all sites in all groups.

As seen in Table 3 and consistent with the patients being closer to end of life, bowel-related documentation was less frequent at the hospices than at the inpatient units, varying between 21% and 44% of admitted days. The frequency of BPS documentation did not appear to reflect poor documentation habits, as performance status was recorded on most days (71%−92%). The proportion of scores between −1 and +1 varied from 44% to 90% of recorded days but contrary to observations on the PCUs, was higher in the hospices that used a "laxative of choice" approach rather than a standard bowel protocol.

The marked differences between sites were explored. At Sites 9 and 10, a wide selection of laxatives was essentially provided at the discretion of each nurse. Sites 11 and 12 were run by a different health authority with a standard bowel protocol.

Follow-Up

Feedback on nurses' experience with the BPS was sought by the study team through ongoing communication with the trained local staff, and it was reported that many nurses reported uncertainty about how to apply the scale when a bowel movement was neither produced nor expected. Suggestions were made as to how the instructions on how to score the BPS in these circumstances could be made clearer.

Table 3
Hospice Results

	Site 9		Site 10		Site 11		Site 12		All Hospice Sites Combined	
	Before	After	Before	After	Before	After	Before	After	Before	After
Number of patients	19	30	25	18	17	20	16	19	77	87
Number of admitted days	286	710	709	386	257	400	281	361	1533	1857
Mean lengths of stay; days	15	24	28	21	15	20	18	19	20	21
Documentation										
BPS recorded; % admitted days	N/A	44	N/A	30	N/A	21	N/A	32	N/A	34
%BPS −1 to +1; total recordings	N/A	90	N/A	82	N/A	45	N/A	44	N/A	74
Last BM recorded on admission; % patients	47	33	48	6	82	75	94	82	62	46
PPS recorded; % admitted days	N/A	74	N/A	76	92	71	N/A	84	N/A	76
Rectal interventions										
≥1 Suppository; % patients	21	47	16	17	29	35	25	32	22	34
≥1 Enema; % patients	21	47	16	17	18	30	25	32	25	33
Side effects										
Diarrhea on ≥1 occasion; % patients	16	70	68	50	29	0	6	21	34	39
Cramps on ≥1 occasion; % patients	21	30	16	22	6	0	0	0	12	15

The PCU that was first to implement the scale (Site 4) collected the bowel flowcharts from all admissions for a further 10-week period starting three months after the study. There was little ongoing education during this time and some staff turnover. There was some falloff in the use of the BPS, with the score recorded on 262 (39%) of 680 admitted days, as compared with 54% during the study. Of those days on which the BPS was recorded, 67% of the scores were between −1 and +1, as compared with 80% previously, illustrating the need for ongoing education and orientation of new staff to the tool.

The Palliative Performance Scale was recorded on 73% of admitted days, and even if the BPS was not scored, some documentation of bowel function occurred virtually every day, indicating that the flow sheets were being used. There were, however, instances of the instructions not having being properly followed, for example, writing the patient's name in the place indicated as "Patient's Normal Bowel Habit," and the symbol Ø being placed in the BPS section instead of a number. As the study flow sheets were not fully incorporated into nursing practice, there was duplicate charting, which was a barrier to consistent documentation.

Staff surveys also were distributed approximately six months after BPS implementation at Site 5, after communication of the results of the chart reviews, but before any further changes had been made to the unit bowel protocol. Responses were received from 15 members of clinical staff: nine registered nurses, four licensed practical nurses, one physician, and one "other." Themes in the responses were positive about the bowel flow sheets and BPS but critical of the unit's constipation management. Six respondents expressed their frustration with other staff sometimes not completing the flow sheet, and the need for the BPS to be incorporated into the unit's permanent charting system. There was widespread comment that "laxative of choice" was not a helpful order. The unit's bowel protocol has been changed in response to this feedback.

Discussion

This implementation study showed that the BPS was an effective tool for patient-centered assessment of bowel function. Regular use of the scale exposed clinically important differences in standards of constipation management among sites and allowed benchmark levels of bowel performance to be established in diverse palliative care populations. When assessed regularly, audit of the proportion of scores between −1 and +1 allowed useful comparisons between units. The scale was easy to implement in the outpatient setting, but was more challenging in the inpatient sites, and required significant nurse education. Modifications to the scale have been made; removing the reference to a three-day interval between bowel movements, and changing the zero (0) score to "G," indicating Goal (see Appendix). Removal of the requirement for double charting would further facilitate effective implementation.

This study has a number of limitations but with respect to applicability, we believe that it was a reasonable test of the BPS in daily clinical use, with real unselected patients, outside of a research environment. Large numbers of patients were assessed by many nurses, at multiple sites, and the educational support they received was consistent with what would be expected to be achievable in routine practice. If used outside of a study setting, with removal of duplicate charting at time of implementation and committed staff being present on-site, we would expect implementation to be much easier. With respect to accuracy, particularly in the outpatient groups, there may have been undocumented discussion between patients and staff in the baseline cohort, particularly if bowel function was satisfactory; however, this would not be useful for audit or for communication with other care providers.

Palliative care is needed for many other chronic conditions but in practice is infrequently available to noncancer patients. Noncancer patients may not experience the same degree of difficulty with constipation as those with cancer, but our experience with limited numbers of noncancer patients suggests the scale is equally applicable whatever the diagnosis.

Although the revised version requires further study, the BPS provided a meaningful clinical outcome measure in our patients, and audit of the recordings led to clinically important improvements in bowel care. We found the proportion of scores between −1 and +1 to be a useful outcome measure for comparing patient groups.

We suggest that to enhance the success of implementation of the new scale, an experienced nursing leader/educator should take responsibility for making sure that all nurses are oriented to the tool and that it is completed regularly. The frequency of use should be determined by clinical context; it should be used more frequently in the acute care setting or when performance status is declining rapidly and expectations of bowel movements are unstable. Integration of patient information and relatively complex decision-making ability are required to be able to complete and respond to the BPS, and some nurses may need ongoing assistance. Careful modification of chart documents is required to ensure that duplicate recording is eliminated and that there is clear direction as to how to modify laxative dispensing according to the scale.

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Appendix

Victoria Bowel Performance Scale (revised) (rBPS)

- 4	-3	- 2	- 1	BPS Score G	+ 1	+ 2	+ 3	+ 4
Constipation			**GOAL**					**Diarrhea**
Impacted or Obstructed ± small leakage 	**Formed Hard with pellets** 	**Formed Hard** 	**Formed Solid** 	**Characteristic** **Formed Semi-solid** 	**Formed Soft** 	**Unformed Loose or paste-like** 	**Unformed Liquid ± mucus** 	**Unformed Liquid ± mucus** 
No Stool produced after Goal plus 3 days	**Goal plus 3 or more days delay**	**Goal plus 1-2 days delay**	**Pt's Goal frequency occurs**	**Pattern** Pt's Goal **for frequency**	**Pt's Goal frequency occurs**	**Goal or more frequent than goal**	**More frequent than goal**	**More frequent than goal**
Unable to defecate despite maximal effort or straining	**Major effort or straining required to defecate**	**Moderate effort or straining required to defecate**	**Minimal or no effort required to defecate**	**Control** **Minimal or no effort to defecate**	**Minimal or no effort required to control urgency**	**Mod. effort required to control urgency**	**Very difficult to control urgency & may be explosive**	**Incontinent or explosive - unable to control or unaware**

Downing, Hawley, Barwich, Black. BPS revised scale. © 2009, Victoria Hospice Society

1. BPS is a 9-point scale. It is a **single score**, based on the overall **"best vertical fit"** among the above three parameters (characteristics, pattern, & control) and is recorded for example as: BPS +1, BPS -3 or BPS G.
2. Look vertically down each BPS level to become familiar with how the three parameters of **characteristics, pattern & control** change in gradation from constipation to diarrhea.
3. For the bowel pattern, it is the patient's **goal** that is the determining factor. The goal is recorded in the center section, marked with the patient's desired goal for how often they would prefer to have a bowel movement. Based on their goal, then the **actual frequency** is either within that goal, delayed beyond the goal, or more frequent than the goal. If the goal is met, the score is **BPS G**.
4. Patients may use different words than above to describe their bowel activity. One must use clinical judgment in deciding which boxes are most appropriate.
5. For patients with ostomies or short bowel syndrome, **all 3 parameters** should be assessed according to closeness to the patient's desired **goal**. In potential confounding cases, determination of the most appropriate BPS score is made using the following methods:
    a. Two vertically similar parameters generally outweigh the third;
    b. Single priority weighting among parameters is Characteristics > Pattern > Control.
6. When recording BPS in hospital or facility patient charts where charting is required every shift or daily, a **BPS "X"** is used to indicate no bowel assessment was done in that time frame. Otherwise, the actual BPS number is recorded. **Do not write "0"** as it is misleading; the correct recording would be **BPS X**.
7. The BPS cannot be applied when there is no expected functioning bowel, as may occur with patients on TPN, or if imminently dying with no oral intake. If this is the case, the correct recording is **BPS N/A.**