HISTORY TAKING – FAECAL SMEARING

Child: _____ DOB: _____/_____/_____

Caregiver: _____ Relationship to child: _____

Clinician: _____ Role: _____

Date of Assessment: _____/ _____/ _____ Child's age: _____

DISCUSSION TOPIC	PARENT REPORT	FURTHER Ax REQUIRED
How would you describe your child's **personality** and interests? **Family** at home (who lives at home, custody, childcare, who helps with morning/ evening routines) When you first notice **smearing**? What do you think contributes to it? What have you already tried?		
BIRTH, DEVELOPMENT & MEDICAL		
Birth *(trauma, meconium 24hr, maternal health)* **Development** milestones **Diagnoses** or medical concerns *(inc allergy/ intolerance in child or family)* **Family or child trauma,** hospitalisation or disruptions early in life **Feeding** history *(reflux, vomiting, grizzly as baby. Present variety, textures, tastes, appetite)* **Communication**: skills and preferences		

TOILETING & FAECAL HISTORY & HYGIENE		
Toilet training history *(bowel/ bladder differences, difficult behaviours or fears, wearing undies or nappies now)*		
Bowel history (constipation, frequency *3-14/week*, medications past/present, stooling at night, insists on nappy to poo)		
Bladder history (incontinence, UTIs, urgency voids *4-8 per 24hr*, drinks *1 – 1.4L/day,* bedwetting)		
Skin integrity & **Hygiene** routines *(% the child prompts using toilet, getting nappy or asking to be changed, skin: red/ inflamed, products used. Can child wipe?)*		
What do you *want* to do when you discover **smearing**? What do you or another carer *do* most of the time?		
SELF CARE, MOTOR & EMOTIONAL		
Sleep (routine, self-settling, staying asleep, waking, hours of sleep, sensory factors, anxiety)		
Dressing (clothes off, clothes on, fastenings, back to front, time taken, physical assist needed)		
Other self-care (grooming, teeth, shower/bath, sensory factors)		
Gross motor (muscle tone/ stability, mobilisation, transfers, balance, sitting)		
Fine motor (grasp, reach, bilateral, dexterity)		

Cognition (multiple instructions, memory, sequencing, planning, attention) **Behaviour** and **emotional regulation** (compliance, response to routine, attention, meltdowns, calming strategies) **Anxiety/ fears** (specific fears, rigid, asks many questions/ repeats questions, hypervigilant, self-soothing strategies such as thumb sucking)		
CHILD'S ENVIRONMENTS		
Home environment *(toilet room and location, equipment in situ, lighting/ toilet paper)* **School/ childcare** environment *(attendance, teacher details, separation anxiety, behaviour when gets home)* **Smearing** at school/childcare? *(If so, when/ how, management plan, key contact)* **Treatment team** (other AHPs, Drs) and appointment schedule		

Take Home Documents Provided:

- ☐ ABCs of Smearing Carer Observational Assessment
- ☐ Body Diary
- ☐ Bristol Stool Form Scale
- ☐ Poo (Emoji) Pain Scale
- ☐ Other resources _____

Impression:

Triggers

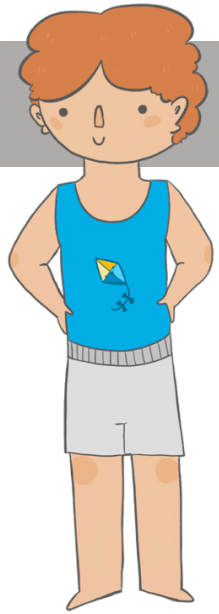
Reinforcers

Actions:

- ☐ Medical review _____
- ☐ Further assessment _____
- ☐ Stakeholder liaison with _____
- ☐ Continence Plan
- ☐ Toileting Behaviour Plan

COMPLETED BY: _____ SIGNATURE: _____

my body diary



What do I record?

Sit: Tick the box when you sit on the toilet after a meal, and highlight it if you did it without being asked!

Poo on toilet: When you do a poo, mark the box with a sticker or a smile and add which number from the *Choose Your Poo* chart that it most looks like.

Oops! If you have wet or dirty undies mark the time of the day with a W (wet) or S (soil/skid). Make sure you write down what you were doing when it happened (eg. Laughing, playing, in the bath, hiding)

Also record any painful wees or poos, sickness or changes in routine (eg weekend at Grandma's, birthday party, took paracetamol for fever). In the medication section record the type of medicine taken for your tummy, including the amount!

Week start date:	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING	☐	☐	☐	☐	☐	☐	☐
LUNCHTIME							
EVENING	☐	☐	☐	☐	☐	☐	☐
MEDICINE (including amount!)							

GOAL!

☐

Kids that go!

Week start date:	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING	☐	☐	☐	☐	☐	☐	☐
LUNCHTIME							
EVENING	☐	☐	☐	☐	☐	☐	☐
MEDICINE (including amount!)							

GOAL!

Week start date:	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING	☐	☐	☐	☐	☐	☐	☐
LUNCHTIME							
EVENING	☐	☐	☐	☐	☐	☐	☐
MEDICINE (including amount!)							

GOAL!

Kids that go!

ABC Smearing Carer Observational Assessment

Please complete this diary every time your child engages in poo smearing or eating poo.

DATE & TIME	WHAT WAS CHILD DOING WHEN SMEARING OCCURRED?	ANTECEDENT What happened just before?	BEHAVIOUR Describe the poo behaviour	CONSEQUENCE What happened next as a result of the poo behaviour?
	Describe their previous activity or interaction	*Who, what, when, where?*	*Where, how much poo, how many areas, type of poo, was anyone else involved?*	*Who, what did they do/say?, what happened after smearing?*

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	Describe their previous activity or interaction	*Who, what, when, where?*	*Where, how much poo, how many areas, type of poo, was anyone else involved?*	*Who, what did they do/say?, what happened after smearing?*

Completed by: _____ Role: _____

Please return this form to your therapist at _____ just prior to your next appointment and bring it with you.

FAECAL SMEARING CHECKLIST & TREATMENT PLAN

Child: _____ DOB: _____/_____/_____

Clinician: _____ Role: _____

Date of Review: _____/ _____/ _____ Child's age: _____

Potential Contributors, Triggers or Reinforcers (tick if present on chart or history)

- ☐ Pain (constipation, diarrhoea, anal fissure/tear)
- ☐ Skin integrity
- ☐ Allergy/intolerance flaring up
- ☐ Recent ABI, seizures, cognitive regression
    - MEDICAL REVIEW + LIAISON
    - SUPPORT TREATMENT COMPLIANCE ESPECIALLY

- ☐ Sensory seeking or avoiding
- ☐ Seeks peculiar smells, tastes, textures
- ☐ PICA and/or Coprophagia
- ☐ Worried/ anxious
- ☐ Clingy/ separation anxiety
- ☐ Trauma (past or present)
- ☐ Self-harm behaviours
    - FORMAL SENSORY ASSESSMENT
    - PSYCHOLOGY REVIEW
    - SDQ OR CONNORS BEHAVIOUR RATING SCALE

- ☐ Balance, proprioception
- ☐ FM skills
- ☐ Eye-hand coordination
- ☐ Motor planning
- ☐ Bilateral skills
- ☐ Vision/ scanning
    - FM OR GM ASSESSMENT (may be observational or standardised)
    - DRESSING/ UNDRESSING FUNCTIONAL Ax

- ☐ Knowledge re poo, wiping, hygiene
- ☐ Not checking
- ☐ Recall
- ☐ Planning
- ☐ Sequencing
- ☐ Attention
- ☐ Visual perception
- ☐ Spatial awareness
    - TASK ANALYSIS (eg PRPP)
    - COGNITIVE ASSESSMENT

Smearing frequency/ intensity at assessment: _____

Suspected key trigger: _____

Goal Setting

1)

2)

3)

Review date:

Treatment Plan

- ☐ Occ Performance Coaching (carer). Aim/s _____
- ☐ Individual therapy sessions. Aim/s _____
- ☐ Home visit/s. Aim/s _____
- ☐ School visit/s. Aim/s _____
- ☐ Case conference _____

COMPLETED BY: _____ SIGNATURE: _____