



Medical Protocol and Procedure

Bowel and Constipation Management

Policy

Constipation is defined as infrequent, incomplete or difficult evacuation of the bowels and is subjectively defined in comparison to what is normal for that individual; it is not based solely on the frequency of stool. Nursing and direct caregivers, in coordination with the individual's primary care physician, will assist the individual to manage bowel habits to increase independence, decrease discomforts and increase the sense of well-being.

Procedure

1. A thorough history and physical examination to be completed by licensed nurse or primary care physician to include the following elements:
 - Patient's normal bowel pattern prior to illness
 - Current stool characteristics, volume, consistency, color, odor, blood
 - Patient's perception of the ease/difficulty (straining) of passing stool
 - Sense of complete evacuation
 - Frequency of stools per day/week
 - Any psychosocial factors that may be inhibiting defecation
 - Compliance with/intolerance to bowel medication
 - Review of medications prescribed, over-the-counter and natural products/ reassess unnecessary medications that may be contributing to constipation
 - Assessment of symptoms such as lack of appetite, early satiety, nausea, bloating, distension, passing flatus, pain, colic
 - Digital rectal examination (DRE) if no BM for 3 days, if not contraindicated (neutropenia, painful conditions, risk for bleeding); assess for anal sphincter tone, presence/absence of stool, possible obstructing masses, hemorrhoids, anal fissures, dilated rectum (may indicate constipation higher in sigmoid area)
 - Special considerations for assessment and treatment for patients with rectal stent, colostomy, ileostomy
 - Determining if diarrhea is overflow diarrhea; rule out other etiologies for true Diarrhea

2. A patient's environment affects how a patient manages bowel functioning. There are many factors to consider including:
 - Toileting at time of maximum peristalsis: upon waking or after meals (30-60 minutes)
 - Proper positioning: over the toilet/commode versus bedpan
 - If the patient must have bowel movement lying down, then place him/her in the left lying position with the hips and knees flexed at 90 degrees
 - Encourage fluids as tolerated
 - Respect privacy/cultural sensitivity
 - Stool chart/ bowel performance scale for a common language for proper



Assessment to allow individual or caregiver to describe & record stool consistency.

3. Oral Pharmacological Approaches in coordination with individual's physician may be indicated and monitored for effectiveness. Individualized bowel regimens will be placed per physician orders.
4. Teach patients to report stool consistency and volume, bowel movement frequency, and ease/difficulty of passage.
 - Teach that stool is still produced despite lack of oral intake (1-2 ounces per day)
 - Advise patients to inform health care practitioner if no BM has occurred for 3 days
 - Educate caregivers, families and health care providers about the advantages of utilizing standardized stool charting to promote consistent assessment and allow patients to describe and record bowel movements in neutral language
 - Do not stop or reduce opioids due to constipation
 - Reinforce the importance of fluid intake
 - Dispel myths about loss of bowel control and constipation
 - Provide Bowel Log for tracking of bowel habits and to help identify concerns.