Instructions for filling out the tracking sheet:

For each shift;

1. Following the stool chartrecord type of stool under the TYPE column
2. Under the OBSERVE BY column
    a. Record R = if resident reported
    b. Record S = if SEEN by staff
    c. Record 0 = if no BM
3. Follow-up notes may include:
    a. Interventions
    b. Bowel management protocol

*full documentation will be in the resident's progress notes

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. **Entirely Liquid**

BOWEL TRACKING PROCESS FLOW

Part of each shift routine is to monitor if the resident had a bowel movement (BM)

↓

If resident is not able to report BM, check for signs and symptoms of constipation

(loss of appetite, abdominal distention, nausea, vomiting, increased flatulence, etc.)

↓

Using the BM tracking sheet note the consistency of BM, using the Bristol Stool Chart

↓

LPN will review physician's orders for bowel management and routine intervention

↓

If NO bowel routine ordered notify physician through the communication binder

↓

If resident is deemed constipated (No BM x3 days). Or if resident is deemed having diarrhea

↓

Follow bowel management routine orders for constipation. Encourage ambulation and increased fluid intake. Or follow bowel management orders for diarrhea, or review Gastro-intestinal illness case definition

↓

Document interventions and evaluations in the appropriate records.