D-00-07-30174

Bowel Care - Laxative of Choice

Site Applicability

Coastal HSDA – Acute Care sites

Practice Level

RN/RPN/LPN: basic skill

Policy Statement

An RN can initiate a laxative of choice without a Physician's Order.

A pre-printed or written Physician's Order will always take precedence.

Upon admission and ongoing, the nurse assesses the patient's bowel function status, patterns and risk factors for constipation and implement appropriate prevention and constipation management interventions.

Need to Know

Constipation is defined as (1) defecation of a hard, formed stool, and/or (2) frequency that is less than the person's usual pattern. This may be accompanied by a prolonged and difficult passage of stool or incomplete evacuation of stool.

Constipation is not associated with normal aging but can be caused by a variety of factors frequently experienced by institutionalized elderly or chronically ill individuals such as illness, decreased mobility, constipating medications, decreased fluid and fiber intake, toileting problems and long standing laxative use.

Equipment and Supplies

In the **absence of a program or site-specific protocols** refer to the following appendices if initiating use of laxatives to manage/prevent constipation.

- All sites: Appendix A: Laxative Function Medication Information Chart
- Acute Care sites LGH, SGH:
  - Appendix B: Acute Care Bowel Routine &
  - Appendix C: Elderly (Acute Sites)

- Palliative patients: Appendix D: Palliative Care Bowel Protocol
- Powell River General Hospital:
  - Appendix E: Acute Care Bowel Routine and
  - Acute Care Bowel Protocol Form #230-337 for documentation *(new)*
- SMH Sechelt: See Site Specific Protocol.

Practice Guidelines

Assessment:
Perform Level 1 and Level 2 bowel function assessments to identify risk for a presence of constipation

ASSESSMENT: Level 1 – Analysis of this information from admission and bowel record data helps nurses to determine if a problem with constipation exists.

1. Previous (if relevant) and current bowel patterns (size, frequency, consistency, ease of expulsion)
2. Previous (if relevant) and current use of oral and rectal laxatives.
3. Abdominal examination to palpate for stool in the descending and sigmoid colon.
4. Rectal examination for presence of stool in rectum if resident has infrequent BMs or difficulty expelling stool.
5. Other signs of constipation such as flatulence, anorexia, fecal oozing/staining.

ASSESSMENT: Level 2 - If a problem with constipation exists, collecting the following information will help to develop a successful plan to treat existing and prevent further constipation.

1. Medical problems or surgeries that would affect current bowel habits, e.g. MS, Parkinson's Disease, Diabetes, CVA, diverticulosis and anorectal, abdominal or pelvic surgery.
2. Current dietary intake with emphasis on fluid and fiber (may need assessment by dietitian).

Patient:
1. Awareness of need to defecate and ability to communicate need.
2. Ability to chew and swallow.
3. Ability to exercise, ability to sit safely & comfortably on toilet/commode Medications that contribute to constipation.
4. Ability to be continent of stool (ability to hold stools until toilet or substitute available).

Interventions to Prevent and Manage Constipation include:

1. Dietary Interventions

Implement preventive measures to soften and bulk the stools at the same time that constipated stool is being cleared.

- *Fluid intake* - Minimum fluid intake should be 1200 mls daily unless contraindicated for medical reasons; 1500-1600 ml is preferable. Ideally, if patients are able, they should drink 30 mls/kg body weight daily. Once current fluid intake has been assessed, consult with the dietitian to assist setting up amounts and type of fluid intake. Refer to the dietitian if the patient has swallowing difficulties. Decaffeinated beverages are preferred.

- *Fiber* - If stools are hard formed or putty-like with little bulk and are difficult to expel and the patient is taking at least 1000 ml fluid, add fiber to the diet with added prunes, high fiber cereal or fruit laxative (ground prunes and wheat bran). Fiber should be increased by no more than 2.5 – 5 gm daily and there

should be one week between increases to allow the gut to adapt to the additional fiber. It can be increased to 30 gm daily if needed. Decrease amount if patient has cramping or loose stools.

2. Other Preventive Interventions

- *Toileting* – the patient should be placed on a toilet or commode after meals, as this is when the gastrocolic reflex is most active. Support the feet as necessary to promote appropriate hip flexion to promote defecation. Hip flexion and a forward thrust of the body increase intra abdominal pressure, which supports defecation with less straining. Patients should be comfortable and have sufficient privacy when having a bowel movement.

- *Constipating Medications* – Review the medications and collaborate with the pharmacist to determine if there are alternate, less constipating medications that are appropriate for the patient and could be discussed with the most responsible provider (MRP).

- *Exercise* – Consult with the OT/PT to explore exercise options for the patient.

3. Laxative/ Pharmaceutical Use

- Treat constipation with laxatives to ensure that the patient has a regular BM. Laxatives work to move stool through the bowel into the rectum by bulking stool and promoting peristalsis. Oral laxatives may or may not promote expulsion.
- If the patient is unable to effectively clear the rectum, use rectal laxatives. Consult the physician if the patient's response to the laxatives guidelines is not satisfactory.
- If the constipation is not resolved with preventive dietary and toileting measures, it may be necessary to continue laxative use.
- If all measures are not successful within 6 days, consult with the MRP. Abdominal x-ray and/or cleansing enema may be required. See evaluation measures below.

Refer to site or program specific protocols (see Equipment and Supplies).

Expected Client/Patient Outcome

The elimination of constipation with the judicious, short-term use of laxatives and the prevention of its recurrence, when possible, through the use of increased dietary fiber and fluid, regular toileting and exercise.

Evaluation

1. Review the bowel record to determine if the patient is passing between 2 and 7 soft formed BMs weekly with each stool being no less than 1 cup. If this is not occurring, increase preventive intervention and consult with the physician.
2. The intervals between stools will be as close to past habits as possible with the use of least invasive measures to support defecation.

Documentation

1. Any change in bowel habits or treatment plans is documented on the progress notes and appropriate assessment & intervention occurs and is documented on the chart as necessary. The physician is notified of any changes as necessary.
2. The Bowel Record is completed each day for each patient.

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Coastal Area Nursing Practice Advisory Council (CANPAC) 5 May 2010

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Date of Creation / Review / Revision

Original publication date: June 1987
Review/revision date(s): Feb/88; Oct/90; Jul/02; May/94; Oct/94; April/01; Sept/08; Dec/08; May/10

Appendix A

Appendix A
Laxative Function Medication Information Chart

LAXATIVE				
Laxative	***Onset***	***Mechanism of Action***	***Dose***	***Common Adverse Events***
Bulk forming	12-72 hours	Absorbs water in the intestine and promotes peristalsis	Consult specific product labeling. Give with at least 8 oz of fluid with each dose. Separate each dose from other drugs by 2 hrs..	Use with caution in the elderly as with insufficient fluids may cause constipation. Abdominal cramps & fecal impaction.
Stool softening surfactants Docusate sodium	1 - 5 days	Allow water to interact more effectively with stool solids, resulting in a softening of stool consistency	Initially 200 mg twice daily	• Diarrhea • Mild abdominal cramping
Stimulants Bisacodyl Sennosides	6 -12 hours (orally) 30 – 120 minutes (rectally)	Stimulate colonic smooth muscle to promote motility, and promote secretion of water into the bowel lumen.	• Bisacodyl: 5-10 mg daily (oral) • Sennosides: 2 to 4 tablets daily; some patients may require 8 or more tablets daily	• Abdominal pain (can be severe) • Fluid/electrolyte disturbances • Urine discolouration • Bowel dependence on laxative use.
Osmotics Glycerin suppositories Lactulose	15 - 60 minutes (glycerin suppositories) 24 - 48 hours (lactulose)	Combination of osmotic effect plus local irritant effect draws water into the GI tract to stimulate bowel movement.	• Lactulose: start with 10 mL daily, up to 60 mL daily. • Glycerin suppository: as needed	• Nausea, flatulence • Rectal irritation
Saline (osmotic ion gradient) • Magnesium citrate • Sodium phosphates • Polyethylene glycol (PEG) (restricted to pediatrids) • Sorbitol • Milk of Magnesia (MOM) • Magnolax (NgOH/mineral oil glycerin)	30 minutes to 3 hours	Relatively non-absorbable cations and anions draw water into the intestine, causing an increase in intraluminal pressure, increasing intestinal motility.	• Magnesium citrate: 300 mL daily. • Sodium phosphates enema: one enema daily • PEG (one heaping Tbsp.) dissolved in 8 oz of water once daily (Paeds only) • MOM: Consult bottle labeling for dose. • Magnolax: Consult bottle labeling for dose.	• Abdominal cramping • Nausea/vomiting / dehydration • Sodium & Phosphate overload (avoid holding sodium phosphate enema in rectum for longer than 30 minutes) • MOM can be used regularly, but other agents are not for routine use. • Avoid magnesium salts in people with renal dysfunction (can cause hypermagnesemia) Creatine Clearane < 30.
Lubricant Mineral oil	6 - 9 hours (oral) 30 minutes (rectally)	Lubrication	• 15 to 30 mL once or twice daily (often given with milk of magnesia 30 to 50 mL twice daily) • More palatable if refrigerated. • Administer on an empty stomach in an upright position.	• Lipid pneumonia • Perianal irritation • Impaired absorption of fat-soluble vitamins • Potential for drug interaction with Coumadin • Not recommended.
Fruit-based fibre (eg. prunes, fruit)	Varies	Softens & bulks stool	Prunes = 3 g/fibre per 4 Fruit-lite = 2.1g fibre per 25 g.	Flatus, diarrhea, bloating

Appendix B

Appendix B

Acute Care Bowel Routine

(Squamish General Hospital and Lions Gate Hospital)

Initiate Laxative use to prevent/manage constipation

Bowel Protocol

Step 1	Initiate If no BM for 1-2 days	Docusate Sodium 200 mg twice daily 9 a.m. - 5 p.m. Sennosides 12 mg x 2 tablets at bedtime (or 8.6 mg x 3 tabs) Increase Sennosides to 12 mg x 4 tablets at bedtime (or 8.6 mg x 5 tabs)
Step 2	If no BM in 3 days (72 hours)	Continue Docusate and Sennosides Add Lactulose 30 cc twice daily
Step 3	In following a.m. if no BM after breakfast (day 4)	Give Bisacodyl or Glycerin suppositories or Microlax enema. Continue with Docusate and Sennosides.
Step 4	If there is no BM after suppositories:	Give Fleet enema. Continue with Step 3 oral medications.
Step 5	If still no BM	Consult with physician and then consider Sodium Phosphates oral solution (oral Fleet) or magnesium citrate solution (Citromag) or large volume enema. (as per Duell et al)

Appendix C

Appendix C

(Acute Care) Elderly

Treatment Guideline	*Oral & Rectal Medication Options*	*Onset of Effect*
Prevention	**Bulk Producing Interventions** 1. High fiber diet / bran / stewed prunes/bulk laxatives 2. Push fluids	Onset 12-24 hours, full effect 2-3 days
Treatment – Constipation **Day 1-2** (after normally expected stool)	Lactulose 15-30 ml daily **OR** Milk of Magnesia if normal renal function (do NOT use if Creatinine Clearance less than 30ml/min)	24-48 hours
Day 2-3 (if no BM Day 1-2)	Lactulose 15-30 ml daily **OR** Milk of Magnesia (see above) Morning preferred dosing time **OR** Sennosides 12-24 mg HS	6-12 hours – full effect 24 hours.
Day 3-4 (if no BM Day 2-3)	Lactulose 15-30 ml daily. **OR** Milk of Magnesia (see above) Morning preferred dosing time **AND** Sennosides 12-24 mg HS **AND EITHER** Glycerin 2.65 g suppository in AM. **OR** Bisacodyl 10 mg suppository in AM	24-48 hours 15-30 minutes 15-60 minutes
Day 4-5 (if no BM Day 3-4)	Continue with lactulose and sennosides as above **AND EITHER** Sodium Citrate and Sodium Lauryl Sulfoacetate (Microlax) 5 ml rectally in AM **OR** Sodium Phosphates (Fleet) 100 ml in AM. **OR** Large volume enema as per Duell, et al and discussion with physician.	6-12 hours 2-5 minutes 5-20 minutes
Treatment – Impaction Day **5-6** (if no BM Day 4-5)	Perform abdominal assessment Disimpact if clinically indicated or Consult physician, may need abdominal xray.	

Appendix D

Appendix D

Instructions for Bowel Care

Using the Palliative Care Bowel Protocol Worksheet (Page 1 of 2) (VCH.CO.3019)

The following guideline is intended for general advice only. Clinical assessment and judgment is unique for each patient circumstance and, along with informed patient and family discussions, should determine the most appropriate plan of care for the patient.

1. Take patient's history

1. TAKE HISTORY: Date of last BM_____ Current BM pattern ☐ daily ☐ Q 2 days Other _____

Goal BM pattern ☐ daily ☐ Q 2 days Other _____

Laxatives prior to admission ☐ None OR List laxatives and doses _____

_____

2. Estimate protocol step. It is the equivalent step to the patient's pre-admission laxative use

2. ESTIMATE PROTOCOL STEP EQUIVALENT TO PRE-ADMISSION LAXATIVE USE:

	A - Stimulant	B - Osmotic	C - Rectal Measures
Step 0	No laxatives	No laxatives	No intervention
Step 1	sennosides 12 mg PO BID	lactulose 10 ml PO BID OR PEG 3350 8.5 g (1/2 sachet) PO BID (according to patient preference)	glycerin suppository x 1 rectal
Step 2	sennosides 24 mg PO BID	lactulose 15 ml PO BID OR PEG 3350 17 g PO BID	bisacodyl suppository 10 mg x 1 rectal
Step 3	sennosides 36 mg PO BID	lactulose 30 ml PO BID OR PEG 3350 17 g PO BID	MICROLAX OR phosphates (FLEET ENEMA EQUIV) enema x 1 rectal
Step 4	sennosides 36 mg PO BID AND lactulose 30 ml PO BID	lactulose 30 ml PO BID OR PEG 3350 17 g PO BID AND sennosides 36 mg PO BID	MICROLAX OR phosphates (FLEET ENEMA EQUIV) enema x 1 rectal
Step 5	Step 4 + PRN rectal medications	Step 4 + PRN rectal medications	Disimpaction

Equivalent Step = ☐
(if on no laxatives, Step 0)

BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate; currently takes hydromorphone and lactulose, 15ml twice per day.

Equivalent step is **Step 2**, as patient already takes lactulose 15ml BID at home.

Example 2: A 78-year-old female has metastatic Ca breast; takes no laxatives at home.

Equivalent step is **Step 0**, as she takes no laxatives at home

3. Choose the most appropriate bowel protocol for the patient's hospital stay:

3. CHOOSE MOST APPROPRIATE BOWEL PROTOCOL FOR HOSPITAL STAY:

A = Stimulant (standard ward protocol)

B = Osmotic (intolerant to sennosides AND taking adequate fluids)

C = Rectal Measures (Palliative Performance Scale less than 20%, minimal/no oral intake) **Protocol A, B or C =** ☐

- Protocol A – Stimulant, or sennosides-based protocol is the standard ward protocol
- Protocol B – Osmotic protocol to be used if there is known Irritable Bowel Syndrome (IBS), previous failure of a properly applied sennosides-based protocol, or patient preference for an osmotic laxative. PEG protocol should only be selected for patients with fluid intake at least 500ml/day
- Protocol C – rectal measures to be selected when patient's PPS is 20% or less (minimal oral intake) Contraindications to rectal intervention are neutropenia (low white blood cells) < 0.5, or thrombocytopenia (low blood platelets) <20.

Continuing with BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate; currently takes hydromorphone and lactulose. His appropriate Bowel Protocol for Hospital Stay will be **Protocol B**, as this is the protocol the patient has come in from home with.

Example 2: A 78-year-old female has metastatic Ca breast; takes no laxatives at home. Her appropriate Bowel Protocol for Hospital Stay will be **Protocol A**, as she didn't use laxatives at home and this is the standard ward protocol.

4. Determine patient's current bowel performance using the Bowel Performance Scale:

4. DETERMINE CURRENT BOWEL PERFORMANCE: BOWEL PERFORMANCE SCALE

- 4	-3	- 2	- 1	GOAL (G)	+ 1	+ 2	+ 3	+ 4
◄ Constipation						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 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

Bowel Performance Scale (BPS) =

Donoghue, Hawley, Barwich, Black BPS revised scale 2009 (©Required to cite)

- BPS is a 9-point numerical scale. It is a single score, based on the overall 'best vertical fit' among the three parameters - characteristics, pattern and control]. BPS is recorded for example as: BPS +1, BPS -3 or BPS +2
- Look vertically down each BPS level to become familiar with how the three parameters of characteristics, pattern and control change in gradation from constipation to diarrhea
- The 'usual' bowel pattern for a patient may be in the 0, -1 or +1 columns. For any of these, the actual frequency of bowel movements may vary among patients from one or more times daily to once every 1-2 days but the patient states that this is their usual pattern
- Patients with a surgical intervention (colostomy, ileostomy, short loop bowel) may have a more frequent 'usual' bowel pattern than above. BPS is still overall graded by combining all three parameters (e.g. +2 or +3 with ileostomy) to ascertain a 'best fit'
- Patients mayuse different words to describe their bowel activity. One must use clinical judgment in deciding which boxes are most appropriate
- In potential confounding cases, determination of the most appropriate BPS score is made using the following methods:
    - Two vertically similar parameters generally outweigh the third;
    - Single priority weighting among parameters is Characteristics > Pattern > Control

Continuing with BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate; currently takes hydromorphone and lactulose. His bowel movements have been regular, but today he states he had two "mushy" stools this morning and "I had to go right away."

His BPS is rated at **BPS +2**. Although his bowel **pattern** has been usual, today frequency increased to twice. Looking at the scale, this probably fits best with the 'usual or frequent' box. The stool **character** is "mushy" and most resembles the 'unformed, loose or paste-like' box. Finally, there was some effort required to **control** his bowels since he noted having to get to the bathroom 'right away.' This could indicate either the +1 box [minimal or no effort to control] or the +2 box [moderate effort required to control]. Taking all three parameters into account, the best overall vertical fit would fall at the BPS +2 rating.

Example 2: A 78-year-old female has metastatic Ca breast. With increasing pain in her back, she has required higher doses of morphine. This has caused bowel troubles for her and she has gone only twice in the last week. The stool was lumpy and hard and it sometimes hurts to pass a BM. She denies having hemorrhoids.

Her score is **BPS -2**. She notes a change from her usual pattern with decreased frequency since "twice per week" she calls 'trouble.' This pattern fits with either -2 or -3, but not -1 or -4. Also, the stool can be painful to pass which indicates some difficulty in control. It is not clear whether this difficulty requires mild or moderate effort but it does not appear to be a major problem. The stool is **characterized** as lumpy and hard which means it is both 'formed' and 'hard' and does not seem by the description to be broken up into pellets. The overall best 'vertical' fit is BPS -2.

5. Now calculate the bowel protocol starting step. This is the patient's initial step on the unit:

5. NOW CALCULATE BOWEL PROTOCOL STARTING STEP:

BPS score	**-4**	**-3**	**-2**	**-1, G or +1**	**+2**	**+3/+4**
Change from equivalent step	**Go up to Step 4**	**Go up one Step +/- Rectal intervention**	**Go up 1 Step**	**Stay at Equivalent Step**	**Go down 1 Step**	**Go down to Step 0**

STARTING STEP = ☐

Continuing with BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate with **Equivalent Step 2** and **BPS +2. Change from equivalent step: Go down 1 Step**; meaning from Step +2 go to Step 1 (refer to protocol step table in number 2), i.e. today the patient should receive lactulose 10 ml PO BID.

Example 2: A 78-year-old female has metastatic Ca breast with **Equivalent Step 0 and BPS -2. Change from equivalent step Go up 1 Step**; meaning from Step 0 go to Step 1 (refer to protocol step table in number 2), i.e. today the patient should receive sennosides 12 mg PO BID.

6. Fax to pharmacy

NURSE TO FAX TO PHARMACY ☐

Instructions for Bowel Care

Using the DAILY Palliative Care Bowel Protocol Worksheet (Page 2 of 2) (VCH.CO.3019)

Use daily worksheet to assess daily Bowel care for Palliative Patients and to determine what step to take next.

Repeat Bowel Performance Scale (number 4):

Determine DAILY bowel performance scale:

- 4	-3	- 2	- 1	GOAL (G)	+ 1	+ 2	+ 3	+ 4
← Constipation						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 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)

Continuing with BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate with **Equivalent Step 2** and **BPS +2** started on **Step 1**. Today patient is reporting that he had one "soft" stool this morning but "I didn't have to go right away, it came easily."

Today his bowel **pattern** and frequency has been usual. Looking at the scale, this probably fits best with the 'usual or frequent' box. The stool **character** is "soft" and most resembles the 'formed soft' box. Finally, there was no effort required to **control** his bowels. This could indicate either the +1 box [minimal or no effort to control] or the G box [control]. Taking all three parameters into account, the best overall vertical fit would fall at the **BPS +1** rating.

Example 2: A 78-year-old female has metastatic Ca breast with **Equivalent Step 0 and BPS -2** started on **Step 1**.

Today she states that she had no stool, and that is 'real trouble' and she usually has a BM every day. This **pattern** can fit with 'Goal plus 1-2 days delay'. It is not clear what the effort that is required to defecate. There is no stool so cannot **characterize** it. The overall best 'vertical' fit is **BPS -2**.

Then determine what is the Bowel Protocol step for today (number 5):

Calculate DAILY bowel protocol step:

BPS score	-4	-3	-2	-1, G or +1	+2	+3/+4
Change from equivalent step	Go up to Step 4	Go up one Step +/- Rectal intervention	Go up 1 Step	Stay at Equivalent Step	Go down 1 Step	Go down to Step 0

Continuing with BPS Case Examples:

Example 1: A 62-year-old male has metastatic Ca prostate with **BPS +1** today.

Calculating today's step = '**Stay at Equivalent Step**'; i.e. if yesterday he was on Step 1 today he stays on **Step 1**. Refer to Protocol Step Laxative Use Table (number 2) and give lactulose 10 ml PO BID.

Example 2: A 78-year-old female has metastatic Ca breast with **BPS -2** today.

Calculating today's step = '**Go up 1 Step**'; i.e. if yesterday she was on Step 1 today she goes up to **Step 2**. Refer to Protocol Step Laxative Use Table (number 2) and give sennosides 24 mg PO BID.

Continue monitoring daily, charting the daily BPS and the daily step:

Continuing with BPS Case Example 1: A 62-year-old male has metastatic Ca prostate.

Date (DD/MMM)	**3/Dec**	**4/Dec**	**5/Dec**													
BPS	**+2**	**+1**														
Step	**1**	**1**														
Comments	**PN**															
Initials																

General Comments for Bowel Protocol

1) Each patient needs to have Palliative Care Admission Orders (#A9218NS) completed upon admission or transfer to the unit.
2) Bowel movements, bowel-related symptoms (cramps etc.) and other assessments are to be documented on Patient Care Flowsheet (A.0019NS #00079697) and in Progress Notes (PN) if needed.
3) At any time, if there is stool in the rectum on examination, or the patient has a sensation of stool which they are unable to pass, consider PRN rectal measures that are listed on the Palliative Care Admission Orders (VCH.CO.LGH.0025).
4) Rectal measures may be deferred to the following morning if appropriate, but this must be clearly charted in Progress Notes and communicated to morning shift.

   ***Contraindications to rectal intervention are neutropenia (low white blood cells) < 0.5, or thrombocytopenia (low blood platelets) <20.
5) If the chosen protocol is not effective or well-tolerated, or patient situation changes (e.g. fluid intake drops to less than 500ml/day), switch to same level of most suitable alternate protocol.
6) Communicate ongoing assessment with patient's physician.

Palliative Performance Scale (PPSv2)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient, which is then assigned as the PPS% score.
2. Begin at the left column and read downward, until the appropriate ambulation level is reached, then read across to the next column and downward again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who had become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and fully conscious.

   Example 3: if the patient is example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40% or 50% since he or she is not 'total care.'
3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.
4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to be prognostic value.

Appendix E

Acute Care Bowel Routine

(Powell River General Hospital)

Initiate Laxative use to prevent / manage constipation.

Bowel Protocol to be initiated following confirmation of no stool or presence of hard stool upon rectal examination.

Step 1	Initiate	Sennosides 24 mg po at bedtime
Step 2 If no BM after 24 hours	Increase dose	Sennosides 24 mg po BID
Step 3 If no BM after 24 hours	Add Lactulose	Sennosides 24 mg po BID Plus Lactulose 15 ml po BID
Step 4 If no BM after 24 hours	Increase lactulose	Sennosides 24 mg BID Plus Lactulose 30 mL po BID
Step 5 If no BM after 24 hours perform rectal exam, abdominal assessment and contact physician PEG 3350	Discontinue above meds. Start PEG 3350. Use with precaution with patients at risk of aspiration.	PEG 3350 17 grams in 240 mL fluid daily.
Step 6 If no BM after 24 hours	Increase PEG 3350	PEG 3350 34 grams in 240 mL fluid daily
Refer to Acute Care Bowel Protocol Form # 230-337 for documentation.		

Vancouver Coastal Health
Promoting wellness. Ensuring care.

Powell River Site

BOWEL CARE PROTOCOL
Acute Care/ALC

MONTH_____ **YEAR**_____

1. Document normal bowel routine prior to admission (if known): # BM/day_____ **OR** #BM/week _____ Usual consistency _____

2. If no BM x 48 hours, perform Rectal Exam to determine:
   - soft stool present in rectum -- consider glycerin suppository OR microlax
   - enema

Initial in box on **appropriate date** given.	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Sennosides (stimulant) Step 1 **Sennosides 24 mg po hs** **2200**																															
Indicate in box BM response (Y or N)																															
If no BM in 24 hours: **1000** Step 2 **INCREASE** TO: **Sennosides 24 mg po BID** **2200**																															
Indicate in box BM response (Y or N)																															
If no BM in 24 hours **1000** Step 3 **ADD**: Lactulose solution (osmotic) **2200** **Lactulose 15 mL BID** And **1000** **Sennosides 24 mg po BID** **2200**																															
Indicate in box BM response (Y or N)																															
If no BM in 24 hours: **1000** Step 4 **INCREASE** TO: **2200** **Lactulose 30 mL BID** And **1000** **Sennosides 24 mg po BID** **2200**																															
Indicate in box BM response (Y or N)																															
 If no BM in 24 hours: 1) Perform rectal check and abdominal assessment. If stool felt in rectum consider glycerin suppository or microlax enema. 2) If no stool felt, notify Physician 3) Discontinue all above medications **CHANGE TO**: **Polyethylene glycol 3350 (PEG) powder dissolved in 240 mL water or juice.** (precaution: patients at risk of aspiration) **PEG powder 17 gram (25 mL) daily** **1000**																															
Indicate in box BM response (Y or N)																															
If no BM in 24 hours: **Step 6: INCREASE** TO**:** **PEG 34 gram (50 mL powder) daily** **1000**																															
Indicate in box BM response (Y or N)																															

*** After ONE day of PEG 34 gram and patient has still not had a BM, physician must be contacted for further direction.**

**** If patient has BM anywhere along the Protocol pathway, nursing to assess and/or consult with physician regarding ongoing regular laxative support to promote regular BM's.**

- Contact physician if rectal pain, bleeding, blood in stools, fever, abdominal pain, abdominal distension, nausea or
- vomiting occur Hold laxative therapy if loose stools or diarrhea occurs and inform physician.
- Document BM's on Clinical Record at bedside; Make notation in Kardex; Document assessments, interventions (ie suppository, microlax) and outcomes in