Bowel Function: Promotion and Maintenance in Long-Term Care

Site Applicability

All VCH & PHC Long Term Care (LTC) sites

Practice Level

Profession	Basic Competency	Advanced Competency (Requiring Additional Education)
RN/RPN	• Assessment of bowel patterns, initiate and sustain individualized bowel care plans, and Fecal Impaction Removal for persons in care	
LPN	• Assessment of bowel patterns, initiate and sustain individualized bowel care plans for persons in care	Fecal Impaction Removal
All regulated health professionals	• All tasks that fall within their scope of practice, role and competencies	
All unregulated professionals	• All tasks as outlined in their roles, responsibilities and job descriptions; **And/Or** Within their employer training and job descriptions and under direction of appropriate regulated/unregulated health care professional	

Requirements

All persons in care will have a clear process in place to promote and maintain bowel function in which nurses will:

- Assess bowel patterns to develop interventions that establish an individualized bowel program to relieve pain and discomfort
- On move-in day, assess each person's bowel history
- Maintain a bowel record for each person in care
- Encourage use of non-pharmacological approaches such as optimal fluid intake, nutrition and activities to maintain a healthy bowel for persons in care
- Follow ostomy care and management plan, if the person in care has an ostomy

All Staff will ensure:

- Persons in care will be free from odour and embarrassment related to the passage of stool pattern
- Persons in care will be encouraged to sit on a toilet
- Ensure privacy, dignity and safety are maintained when person is on the toilet

Need to Know

- Many factors that increase the risk of constipation are common in individuals who live in long-term care (see Appendix A).
- Inter-professional assessment of bowel function is important to determine interventions that will treat and prevent constipation.
- It is important to implement non-pharmacologic strategies to avoid over use of medications and reduce polypharmacy.
- Enema use is discouraged due to potential side effects and is therefore limited to use as a last step intervention.
- Constipation induced due to ongoing opioid use will require further pharmacological interventions (See Palliative Care Bowel Protocol for further guidance).
- It is important to know the type of ostomy a person has. If ostomy present, follow ostomy care and management plan
    - If ileostomy has high output (greater than 1.2 to 1.5 L per day) (Burgess-Stocks, 2020), then consult a Nurse Specialized in Wound, Ostomy and Continence (NSWOC) and Registered Dietitian (RD).
    - Ileostomies rarely require laxatives and bowel interventions

Guideline

This guideline is to assist the team to conduct a thorough assessment in a consistent manner. This is referred to on admission, when there is a change in the person's health condition, change in their bowel pattern and as indicated in the RAI MDS 2.0 standards. After a thorough assessment, the nurse initiates, documents and implements the most appropriate interventions.

Nursing Assessment

Initial Assessment

Within 24 hours of moving-in to a LTC site, the nurse assesses the person's bowel status (Appendix B).

Daily Assessment

- Approximate fluid and all food intake
- Number of bowel movements (BMs)
- Character of stool – refer to Bristol Stool Scale (Appendix C)
- Amount
- Episodes of constipation/fecal soiling
- Use of laxative interventions and response

- Evaluation of BMs as identified by the persons/family/previous nursing assessments

Additional Assessments

The nurse performs further assessments (abdominal and/or rectal examination) as clinically indicated (see bowel complications section below).

If chronic constipation is a focus of concern, the nurse consults with the registered dietician (RD) and members of the interdisciplinary team as appropriate. When administration of a suppository is necessary, for persons not already on an established bowel care plan (demonstrating signs & symptoms outside of their normal bowel care pattern per the bowel record), the nurse will need to conduct a digital rectal examination/assessment prior to administration of the suppository (Embleton, 2020).

Interdisciplinary Prevention and Intervention Measures for Constipation

All persons should receive non-pharmacologic interventions (daily or as needed – based on any identified contributing factors for constipation) including:

1. **Encourage fluid intake** of approximately 1500 mL/day in persons who are not on fluid restrictions.
    a. Review orders for fluid restriction prior to encouraging increased fluid intake.
    b. Consult RD and/or Most Responsible Provider (MRP) for the fluid intake goal if person has history of heart failure or renal failure.
    c. Place fluids within easy reach of persons.
    d. Offer persons fluids between meals.
    e. Support and offer persons living with dysphagia with frequent offerings of fluid to maintain hydration.
    f. Offer fluids with medications (e.g. 125 to 250 mL).
2. **Eating fibre-rich foods** in combination with fluid intake and activity, may improve bowel movement frequency, stool consistency and quality of life, and potentially decrease laxative use. Fiber should be added gradually to avoid cramping and distention. Consult RD as appropriate.
    a. A high fibre diet is contraindicated in persons who are on fluid restrictions of less than 1500 mL/day and for persons who are immobile or bedbound.
    b. Once person is achieving consistent fluid intake of at least 1500 mL per day, encourage increased dietary fibre (e.g. fruit lax***,** wheat bran, vegetables, whole grains).
        i. *****Fruit lax is contraindicated in persons if eGFR is less than 30 mL/min (due to risk of hyperkalemia) (BC Renal Agency, 2017). Fruit lax can be spread on toast or mixed in foods such as oatmeal or yoghurt. Fruit lax is beneficial because it draws water into the bowel.
    c. Monitor for abdominal bloating and discomfort while increasing fibre as this may indicate the need to reduce fibre intake. RD consult is strongly recommended when abdominal bloating and/or discomfort is noted after increasing fibre intake.

3. **Low intensity physical activity** can improve a variety of facets of health, including preventing constipation, when combined with fluids and fibre intake.
    a. Encourage participation in activities as tolerated, including functional mobility where already assessed to be appropriate and safe.
4. **Regular, consistent toileting.** Ignoring the urge to defecate, inaccessible toilets and/or lack of toileting assistance can contribute to constipation and fecal incontinence.
    a. Regular toileting based on the person's triggering meal (typically 5 to 40 minutes after breakfast) and within two hours of waking.
    b. Encourage person to sit in an upright position with knees higher than the hips, and with feet supported (they must be able to tolerate independent unsupported sitting balance). Do not leave the person for longer than 20 to 30 minutes and stay with them if they are at risk for falls.
    c. Persons may benefit from scheduled toileting in accordance to their daily identified bowel pattern.
    d. Bedbound persons assessed as having the necessary range of motion to support the left-side lying position may benefit from bending the legs toward the abdomen. This facilitates the use of abdominal muscles to help with defecation and the left-side lying position facilitates movement of feces.
    e. Provide and safeguard privacy.
    f. Watch for behaviours that may indicate the need for toileting in persons who have dementia (e.g. restlessness, unusual vocalization, or agitation).
5. **Medications to treat constipation (Nursing only)**
    a. Some individuals will experience constipation despite non-pharmacologic measures.
    b. Continue the non-pharmacologic measures and follow the bowel protocol (Appendix D) to guide selection of PRN bowel medications.

Bowel Related Complications

Resident care aides (RCAs) should review the care guide for details of the person's individualized bowel plan and report the following symptoms to the nurse:

- Symptoms of constipation (example: small, hard stools passed by straining or less than three bowel movements in a week, or discomfort when defecating)
- Excessive flatulence
- Diarrhea
- Fecal incontinence
- Abdominal discomfort/pain

Nurses who receive information suggesting bowel complications, should conduct an assessment and identify barriers to maintaining or re-establishing bowel regularity. The nurse should be on alert for concerning indicators of complications to communicate to the most responsible interdisciplinary team member.

Clinical indicator	Nurse Actions

Pain or bleeding with bowel movement	• Complete a pain assessment.
	• Assess for the source of the bleeding and consider:
	  ○ presence of hemorrhoids
	  ○ black or dark stools
	  ○ open wounds
	  ○ bleeding stoma – consider NSWOC consult
	• Communicate with MRP when moderate to high levels of pain (as reported by the person) OR assessment reveals moderate to high levels of bleeding.

New acute onset or chronic ongoing abdominal pain	• Conduct focused assessment:
	  ○ Pain: Onset/other symptoms, provoke or palliate, quality, region or radiate, severity, timing or treatment, understanding and values
	  ○ Nausea and/or vomiting
	  ○ Bowel movement history
	  ○ Appetite
	  ○ Abdominal distention/rigidity
	  ○ Bowel sounds
	• Use clinical judgment based on findings to proceed to full head-to-toe assessment and communicate findings to MRP as appropriate.

New onset fecal incontinence	• Assess for potential causes:
	  ○ **Delirium**: Perform CAM screen. If positive follow Delirium: Screening, Assessment and Management guideline and communicate with MRP
	  ○ **Infection**: Assess person and review history for potential sources of infection (e.g. *c.difficile*, suspected outbreaks). Report to MRP. Follow infection control guidelines.
	  ○ **Medication**: Review Medication Administration Record (MAR) for recent antibiotics (*c.difficile* risk), laxative administration, new medication prescriptions, etc. Consult MRP or pharmacist as appropriate.
	  ○ **Food intolerance**: Ensure person has not received food listed as intolerance (e.g. lactose). Consult RD as appropriate.
	  ○ **Overflow incontinence**:
	  ○ Assess for fecal impaction by digital rectal exam.
	  ○ Communicate with MRP if no stool found in rectum. The person may require X-ray to confirm proximal fecal impaction.
	  ○ Prioritize regular toileting schedule.
	  ○ Consult RD for guidance on fluid and fibre intake and recommendations.

	○ Continue to encourage activity where appropriate ○ Consult MRP or pharmacist if medication side effect(s) observed. ○ If person has an ostomy and fecal incontinence is suspected, consult NSWOC.
No bowel movement after 4 to 5 days, suspected fecal impaction	If person has signs of chronic constipation, consider fecal impaction**:** • Examine rectum for presence and consistency of stool (**if the person does not have an ostomy**) • Treatment options include manual removal of stool when the fecal mass is palpable in the rectum (Appendix E). Softening of hardened stool and stimulation of evacuation with enemas or suppositories is often helpful. (Serrano Falcón, 2016) • If ostomy present, consult NSWOC.

Documentation

- Record approximate fluid and meal intake, number of bowel movements, use of laxative interventions and response
- MAR documentation: all bowel medications administered, including PRN medication
- Resident Assessment Instrument-Minimum Data Set 2.0 (RAI-MDS 2.0 – H1a & H2) with consideration of: control of bowel movement, bowel elimination pattern presence of constipation, diarrhea
- Document non-pharmacological strategies for bowel care in person's care plan
- Progress Notes: bowel related complications, interventions and associated responses.
- Document any person and/or family education provided

Person and Family Education

Education for person and families is available from the Patient Health Education Materials.

Evaluation

- An evaluation date is set by the nurse creating the initial bowel care plan. The evaluation date is revised by the nurse as needed, based on further assessments.
- Review bowel record to determine if the person has passed sufficient stool regularly according to individualized pattern.
- Confirm that person is comfortable with bowel regularity and bowel program.
- Update care plan and care guide after evaluation performed.

Related Documents

D-00-12-30373 (VCH document) - Autonomic Dysreflexia: Care and Management

BCD-07-40081 - Delirium: Screening, Assessment and Management

D-00-07-30067 – Basic Pain Assessment & Management of Older Adult in Long-Term Care

BD-00-07-40050 - Ostomy care and management

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Definitions

Autonomic dysreflexia is a cardiovascular complication that can happen to individuals with spinal cord injury above T6 vertebra, in which the body responds with exaggerated sympathetic responses to noxious stimuli (like fecal impaction or bladder distention). Typical symptoms include rapid onset headache, slow heart rate and high blood pressure. This condition can be life threatening. Treatment includes positioning the person upright to lower blood pressure and avoiding/correcting the noxious stimuli.

Fecal impaction means the inability to evacuate dry, large and hard stool lodged in the lower gastrointestinal tract, most likely the rectum.

Overflow Fecal Incontinence is the involuntary loss of stool due to an overfull rectum or fecal impaction.

Constipation is a symptom and not a disease. There are two different views of how constipation is defined. One is the patient's view which is: Different patients have different perceptions of symptoms. Some patients regard constipation as straining (52%), while for others, it means hard, pellet-like stools (44%) or an inability to defecate when desired (34%), or infrequent defecation (33%). The other is the clinical view: There is constipation if patients who do not take laxatives report at least two of the following in any 12-week period during the previous 12 months (the Rome Criteria):

- Fewer than three bowel movements (BMs) per week
- Hard stool in more than 25% of BMs
- A sense of incomplete evacuation in more than 25% of BMs
- Excessive straining in more than 25% of BMs
- A need for digital manipulation to facilitate evacuation

Appendices

Appendix A: Conditions that Cause or Contribute to Constipation

Underlying Condition	Contributing Factors
Malnutrition	• Inadequate food intake • Inadequate fluid intake • Poor appetite
Cancer/cancer-related	• colorectal cancer • dehydration • intestinal radiation • tumour compression of large intestine
Endocrine disorders	• diabetes • hormonal changes • hyperparathyroidism • hypothyroidism
Gastrointestinal disorders	• diverticulosis • Hirschsprung's disease • irritable bowel syndrome • megacolon • rectoceles • strictures
Metabolic conditions	• hypercalcemia • hypocalcemia • hypomagnesemia • hypokalemia • uremia
Neurological conditions	• autonomic neuropathy • dementia • multiple sclerosis • muscular dystrophies • Parkinson's disease • spinal cord lesions • stroke
Psychological conditions	• anxiety • depression • eating disorders
Other	• chronic kidney disease • hemorrhoids • increased age

	• sexual abuse • systematic sclerosis

List from: (Registered Nurses of Ontario (RNAO), 2020)

Medications can increase the risk of constipation by:

- Slowing down peristaltic contractions
- Decreasing neurological stimulation of the bowel
- Decreasing gastric motility
- Decreasing absorption rates
- Limiting general personal mobility

Polypharmacy (having multiple medications, particularly over seven) is associated with increasing risk of constipation.

Medications that can cause constipation:

- Analgesic drugs: nonsteroidal anti-inflammatory drugs, opioids (25% to 40% in non-cancer patients and 90% or more in cancer patients)
- Anticholinergic drugs: antipsychotic drugs, benztropine, oxybutynin
- Anti-Parkinson drugs: amantadine, bromocriptine, pramipexole
- Anticonvulsant drugs: gabapentin, phenytoin, pregabalin
- Antidepressant drugs: tricyclic antidepressants, paroxetine
- Antidiarrheal drugs: diphenoxylate, loperamide
- Antiemetic drugs: dimenhydrinate, ondansetron, prochlorperazine, promethazine, scopolamine
- Antihistamine drugs: diphenhydramine, hydroxyzine
- Antihypertensive drugs: α-adrenergic agonists (eg, clonidine), β-blockers, calcium channel blockers (especially verapamil), diuretics
- Antispasmodic drugs: dicyclomine
- Cation agents: aluminum, bismuth, barium, calcium, iron
- Chemotherapy: vincristine, cyclophosphamide
- Resins: cholestyramine, sodium polystyrene sulfonate

List from (Schuster, 2015)

Appendix B: Assessment of Bowel Function

1. Obtain a baseline history of person's bowel pattern:
    a. type and quantity of stool
    b. frequency and timing of bowel movements
    c. difficulties or straining during bowel movements
    d. historical use of laxatives
    e. person's goal for bowel pattern

2. Assess stool consistency using a Bristol Stool Chart (Appendix C).

3. Review Long Term Care Daily Flow Chart for seven-day diet history of daily fluid and fibre intake.

4. Conduct a review of medications at every care conference and PRN in conjunction with pharmacist.

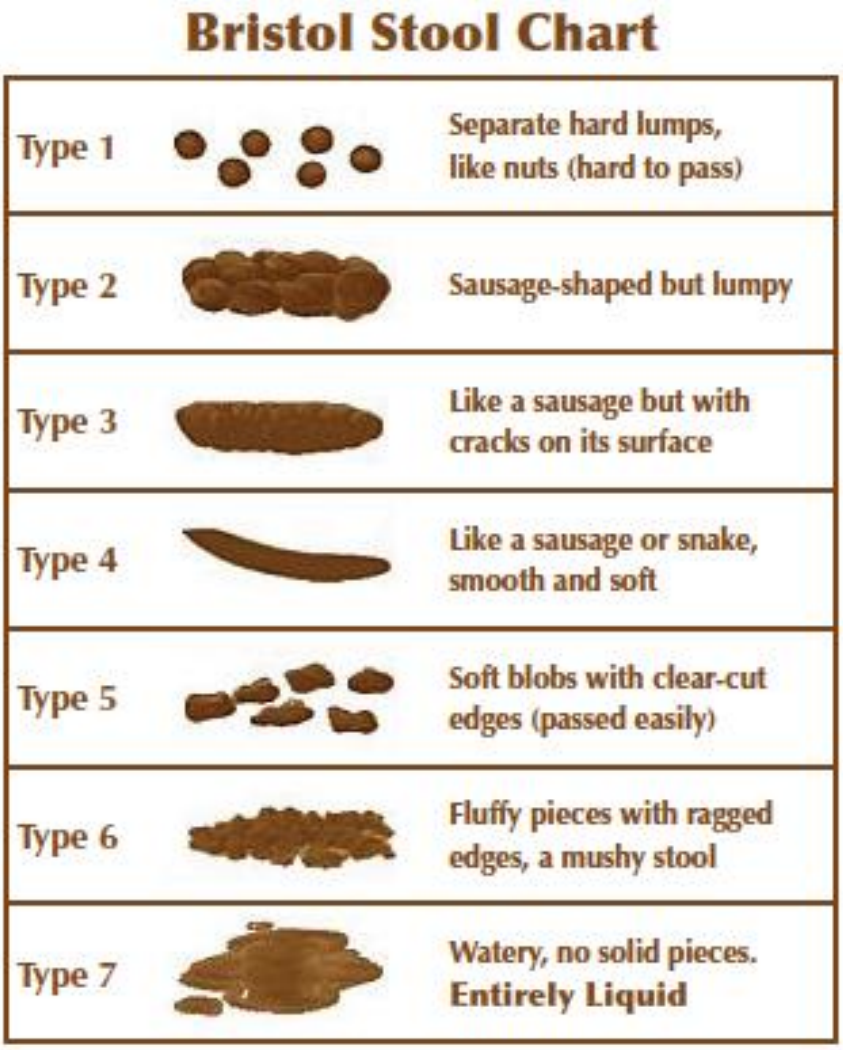
5. Examine co-morbid conditions that may cause or contribute to constipation (Appendix A).

6. Assess the individual's functional and cognitive status to identify barriers and facilitators of a regular bowel pattern.

7. As clinically indicated, perform a digital rectal examination to determine fecal impaction.

Adapted from: (Registered Nurses of Ontario (RNAO), 2020)

Appendix C: Bristol Stool Chart



Stool types one and two indicate constipation.

Appendix D: Protocol for Treating Constipation in LTC

This protocol is to guide nurses in selecting as needed bowel medications from the Cerner: Long-Term Care Bowel Protocol (Module) order set. Nurses must consider regular bowel medication orders when following this guidance.

DO NOT initiate constipation protocol if any of the following are present (consult MRP):

- ileostomy
- bowel sounds are not heard
- abdomen is distended
- abdomen is painful – i.e. person complains (or shows signs of) severe abdominal pain
- abdominal mass is palpated that is of unknown origin
- significant change in person's level of consciousness or mental status
- person is vomiting

Implement standard interventions when safe: fluid and fibre intake, activity, and consistent toileting. Consult and involve allied health as appropriate.

Status	Medical Direction – Order Required	Onset of Action	Notes	Include person/family in shared decision making as appropriate.
Bowel Assessment Performed Indicates Constipation	Cerner: Long Term Care Bowel Protocol (module)			
24 hours no bowel movement	✓ No laxative required - If this observed stool is in Bristol 1 or 2 category, give PEG 3350 Powder (dose as per order)		✓ Offer preferred dietary intervention DAILY (e.g. apple or prune juice at breakfast, prunes, apple slices, fruit laxative*- *fruitlax) ✓ Toilet after breakfast.	
48 hours no bowel movement	Continue prevention measures. <u>Osmotic Laxative</u> PEG 3350 Powder (dose as per order) (if not already receiving) **OR** Lactulose PO (Dose as per order) in the morning (select dose based on order) <u>Stimulant Laxative</u>	Sennosides: 6 to 12h	PEG has delayed onset of action and can be useful in chronic constipation. Person should drink 250 mL of fluids with PEG	

	Provide sennosides (dose as per order) by mouth at bedtime x 1			

72h no bowel movement	Osmotic Laxative PEG 3350 Powder (dose as per order) (if not already receiving) **OR** Lactulose PO (Dose as per order) in the morning (select dose based on order) **AND,** if not effective, Choose suppository per rectum x 1 Stimulant Laxative Bisacodyl rectal suppository (dose as per order) **OR** Osmotic Laxative Glycerin Adult rectal suppository If suppository is not effective by bedtime then can administer: Stimulant Laxative Provide Sennosides (dose as per order) by mouth at bedtime x 1	Lactulose 24 to 48h Bisacodyl supp 15 to 60 min Glycerin 15 to 60 min Sennosides: 6 to 12h	Nurse may substitute magnesium hydroxide for morning medication in persons WITHOUT cardiac or renal impairment**.	**Include person/family in shared decision making as appropriate.**
96h no bowel movement	Sodium phosphate enema*** (Fleet) rectally x 1 (if eGFR greater than 30 mL/min) Notify MRP if ineffective after 12 hours. Notify MRP to review regular laxatives.			

*Do not administer fruit laxative to persons with eGFR less than 30 mL/min

** Do not administer magnesium hydroxide to persons with eGFR less than 30 mL/min

** Do not administer magnesium hydroxide to persons with history of heart failure.

***Do not administer sodium phosphate enema to persons with eGFR less than 30 mL/min

Important Note: Nurses may tailor the above interventions specific to the needs of the persons within their home in consultation with interdisciplinary team and person's individual wishes.

Appendix E: Digital Stimulation / Disimpaction of Feces (Mitchell, 2019)

A complete bowel assessment MUST be performed first.

Per BCCNM guidelines, LPNs require specialized additional training to perform this procedure.

Indications:	Contraindications:
• Presence of large amount of stool in the rectum • Inability to defecate • When other methods of bowel evacuation have failed or deemed inappropriate	• Person has recently undergone rectal surgery • Any indication of trauma to the anal or rectal area • Person with a Stoma (persons with a stoma *should not* have a digital rectal exam and/or a digital stoma exam)
Caution: • In the presence of swelling, bleeding or pain at the rectal area, consult with MRP before proceeding.	

For individuals with spinal cord injury above T6: obtain blood pressure before, during, and post procedure (unless the person is already on an established bowel care plan, then vital signs may not be necessary), if disimpaction is not routine for that individual. Observe for symptoms of autonomic dysreflexia. If symptoms occur, abort procedure and sit person up. Repeat blood pressure assessment and communicate with MRP. Observe person at all times for signs of distress (pain, bleeding).

Steps:

Prior to beginning procedure:

1. Nurse performing exam to ensure their nails are cut short.
2. Discuss with person and seek their consent
3. Ensure privacy
4. Perform hand hygiene
5. Apply two pairs of gloves
6. Position person on their left side, knees flexed, with the upper knee higher than the lower knee and buttocks near the edge of the bed
7. Place lubricant gel on gloved finger
8. Inform the person that the procedure is about to begin

9. Gently insert the lubricated finger into the anus and slowly advance into the rectum
10. Check the stool type.
    - If it is type 1 on the Bristol Stool Form Scale, remove one lump at a time until no feces are felt. This will relieve person discomfort.
    - If the fecal matter is more than 4cm across and is too hard and solid to break up, discontinue the procedure to avoid any pain or damage to the anal sphincter and discuss other approaches with the interdisciplinary team.
    - If the stool is soft gently circle the finger continuously to remove faeces
11. Take care not to cause rectal trauma. Avoid using a hooked finger to remove faeces, this may damage intestinal wall
12. Remove top glove layer and clean person's anus and buttocks
13. Remove bottom glove layer
14. Perform hand hygiene
15. Reposition person
16. Document

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Owners: *(optional)*	PHC	VCH
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