Complex Bowel Care Procedures
Appendix 1: Bristol Stool Chart

BRISTOL STOOL CHART

TYPE 1 - SEVERE CONSTIPATION
Separate, hard lumps

TYPE 2 - MILD CONSTIPATION
Lumpy and sausage like

TYPE 3 - NORMAL
A sausage-shape with cracks in the surface

TYPE 4 - NORMAL
Like a smooth, soft sausage or snake

TYPE 5 - LACKING FIBER
Soft blobs with clear-cut edges

TYPE 6 - MILD DIARRHEA
Mushy consistency with ragged edges

TYPE 7 - SEVERE DIARRHEA
Liquid consistency with no solid pieces

Complex Bowel Care Procedures Appendix 2: Constipation

Definition of Terms

Constipation is determined following a bowel assessment and can be characterised by straining on defecation, reduced or infrequent defecation (<3 per week) or a feeling of incomplete emptying of the rectum.

Faecal impaction is a state in which the person becomes so severely constipated that they are unlikely to be able to pass faeces of their own accord. It is usually but not necessarily, associated with hardened stools and participant discomfort. It is a major cause of faecal incontinence. Often presents as faecal incontinence or overflow diarrhoea.

Management and Assessment

Management includes:

- high-dose oral laxatives
- suppositories and enemas
- manual dis-impaction.

Assessment / Management

- establish when usual bowel activity last occurred and document on bowel chart.
- refer to documentation section for appropriate form(s)
- refer to fluid balance work sheet to evaluate if fluid intake adequate
- promote 2L per day as clinically appropriate
- promote well balanced diet and monitor dietary intake as appropriate
- liaise with Dietitian as indicated
- promote physical activity/ exercise as able
- consider referral to Physiotherapy especially if immobile.

The management of constipation depends on the cause, with many participants being affected by more than one causative factor.

Faecal impaction should be confirmed following assessment by a Health Practitioner. Dietary and lifestyle changes are usually the first steps in treatment. They should be encouraged and continued, recognising the individual's limitations, even if laxatives are used.

Changes include:

- adequate dietary fibre intake (18–30 g daily is recommended for adults; increase intake gradually to avoid bloating and flatulence; may be less beneficial in slow transit constipation)
- adequate fluid intake
- increasing activity/exercise
- immediately responding to the urge to defecate and using the toilet after meals because gastrocolic reflex is maximal.

Refer to Australian Quality Care's *Management of Medication Policy and Procedure* and the Australian Medicines Handbook – gastrointestinal drugs – constipation section. This section

provides current guidance on the following drug choices in managing constipation, including product information:

- Bulk-forming laxatives
- Osmotic laxatives
- Stool softeners
- Stimulant laxatives
- Suppositories and enemas
- Opioid antagonists
- Other laxatives.

Do not administer rectal medication to participants with:

- Neutropoenia
- Thrombocytopaenia
- A history of recent colorectal surgery.

Long-term laxative use is not necessary unless constipation or faecal impaction is likely to recur, e.g., opioid-induced constipation, progressive neurological conditions, immobility due to old age or illness, and in some children to prevent relapse.

Do not stop laxatives abruptly when treating chronic constipation - withdraw gradually 2–4 weeks after regular pattern established.

Complex Bowel Care Procedures
Appendix 3: Diarrhoea

Definition of Terms

Diarrhoea can be characterised by decreased stool consistency, increased frequency, urgency, volume, or weight may also be indicative of diarrhoea. Diarrhoea is a symptom, and the underlying cause should be identified and treated if possible. Assessment and correction of dehydration and electrolyte disturbances is a priority in treatment. Exclusion of diarrhoea secondary to faecal impaction is important.

Acute diarrhoea is a rapid onset and present for less than 2 weeks. Episodes of acute diarrhoea should be considered potentially infectious until otherwise proven. Consult local infection control consultant/nurse if indicated.

Chronic diarrhoea is persistent and has been present for more than 2 weeks. Symptoms can range from abdominal cramping to severe abdominal pain and there may be burning and/ or itching around the perianal area.

Risk Factors

Risk Factors
Severe or extended diarrhoea may result in dehydration, electrolyte imbalance and malnutrition, anxiety, stress, and depression.

Risk factors that may predispose diarrhoea include:

- recent overseas travel
- surgery e.g., abdominal, and colorectal
- infection
- gastrointestinal tract disorders
- malabsorption syndromes
- lifestyle e.g., excessive alcohol intake
- psychological factors /psychiatric history
- medications including over the counter and/or complementary therapies
- food allergies and intolerance
- Graft Versus Host Disease (GVHD).

Medications which may cause diarrhoea include, but are not limited to:

- Antibiotics
- Non-steroidal anti-inflammatories
- Laxatives
- Antihypertensives
- Antiarrhythmics
- Bronchodilator
- Antineoplastics
- Chemotherapy.

Management and Assessment

1. Assess when normal bowel activity last occurred and document appropriately.

2. Refer to *Bristol Stool Chart* to determine stool assessment including:
    - frequency
    - consistency
    - colour
    - volume, including mucous, blood, pus, excessive fats, undigested food or tablets
    - offensive odour.

3. Commence monitoring and document intake and output to identify problems such as dehydration.

4. Implement transmission-based precautions in participants where the suspected or confirmed infectious agent represents an increased risk of transmission. Refer to *Infection Control Policy and Procedure.*

5. Assess and record episode of:
    - pain or discomfort
    - vomiting
    - generalised weakness
    - assess perianal area for signs of impaired skin integrity.

6. Treatable factors of diarrhoea or faecal incontinence should be addressed prior to initiation of a *Complex Bowel Care Support Plan*.

7. Initiate review by Health Practitioners who may consider:
    - Analgesia
    - Anti-motility medications (refer to Australian Medicines Handbook – gastrointestinal drugs – drugs for diarrhoea section for more information)
    - Anti-emetics
    - Intravenous (IV) therapy/ electrolyte replacement
    - Stool specimen collection for microbiology, culture, and sensitivity (if not already undertaken)
    - Digital rectal examination
    - Abdominal X-ray.

8. Consider Dietitian review in liaison with Health Practitioner for:
    - review of nutritional status e.g., dietary intake
    - review of causative factors e.g., food allergies and intolerance
    - review to ensure safe route for nutrition is considered.

Complex Bowel Care Procedures
Appendix 4: Faecal Incontinence

Definition of Terms

Faecal incontinence can be defined as the involuntary passage of solid or liquid faeces and/or flatus. Causes:

- faecal impaction with overflow
- anal sphincter/pelvic floor damage
- degenerative neurological disease e.g., Alzheimer's dementia
- ano-rectal pathology such as rectal prolapse
- gut motility/stool consistency i.e.: infection, pelvic irradiation, irritable bowel syndrome, inflammatory bowel disease, dietary intake
- environmental/ lifestyle, e.g., poor toileting facilities, physical/mental impairment
- idiopathic.

Risk Factors

Risk Factors

Risk factors may include:

- age
- gender
- constipation/faecal impaction
- diarrhoea
- cognitive impairment.

Management and Assessment

1. Assess when normal bowel activity last occurred and document appropriately.

2. Refer to *Bristol Stool Chart* to determine stool assessment including:
   - frequency
   - consistency
   - colour.

Special management is required for those individuals:

- who are severely or terminally ill
- with spinal cord injury
- with intellectual disability.

3. Liaise with Registered Nurse to:
   - treat any potentially reversible causes such as: Faecal loading, Treatable causes of diarrhoea e.g., infective, inflammatory bowel disease, rectal prolapse, acute anal injury, acute injury such as disc prolapse.
   - consider alternatives to medications that may be contributing to faecal incontinence.

4. Promote regular time for defecation:
   - As per participant's usual time or 30 minutes after meals
   - Encourage the participant to respond immediately to defecate.

5. Encourage participant to adopt correct sitting position on the toilet and to avoid straining.
6. Ensure appropriate dietary intake to promote ideal stool consistency.
7. Consult with Dietitian as appropriate.

Complex Bowel Care Procedures
Appendix 5: Administering Enemas

Equipment Required

Equipment required:

- Bed pan
- Gloves
- Apron
- Lubricating gel
- Enema.

Procedure

1. Obtain careful history from participant prior to examination, including establishing whether participant has any known allergies.

2. Establish indications for use and eliminate any contra-indications or allergies prior to proceeding.

3. Ensure participant is introduced to support worker involved in the procedure.

4. Explain each step of the procedure to the participant, including potential risks and complications, and the benefits.

5. Obtain valid and informed consent and document in participant's health records.

6. Identify participant by surname, first name and date of birth using open questions checking against NDIS number.

7. Establish that the participant has no known allergies.

8. Clarify if the participant requires a formal chaperone.

9. Check enema to be administered against Medicines Administration chart or, if at discretion of the Health Practitioner (and in accordance with policy), document the administration appropriately.

10. Ensure Medicines Administration chart specifies:
    - participant's full name
    - participant's date of birth
    - Prescriber's signature and date prescribed
    - Name of suppository/enema to be administered
    - Dose to be administered
    - Route of administration
    - participant's allergy status.

11. Allow participant to empty bladder first if required.

12. Ensure a bedpan, commode or toilet is readily available.

13. Decontaminate hands as per *Infection Prevention and Control Policy and Procedure* (Hand Hygiene Procedure) and apply gloves and apron (single use nonsterile disposable).

14. Prepare the enema by warming to body temperature in accordance with manufacturer's instructions.

15. Assist the participant to lie on the left side, with knees drawn to the abdomen, and buttocks near the edge of the bed.

16. Place some lubricating gel on nozzle of enema.

17. Expel excessive air from enema prior to administration.

18. Inform the participant that you are about to commence the procedure, slowly introduce the nozzle to the depth recommended by the manufacturer.

19. Introduce the fluid slowly as recommended by the manufacturer.

20. Once instilled, slowly withdraw the nozzle.

21. Ask the participant to retain the enema for 10-15 minutes before evacuating the bowel.

Complex Bowel Care Procedures
Appendix 6: Administering Suppositories

Equipment Required

Equipment required:
- Bed pan
- Gloves
- Apron
- Lubricating gel
- Suppository.

Procedure

1. Obtain careful history from participant prior to examination, including establishing whether participant has any known allergies.

2. Establish indications for use and eliminate any contra-indications or allergies prior to proceeding.

3. Ensure participant is introduced to support worker involved in the procedure.

4. Explain each step of the procedure to the participant, including potential risks and complications, and the benefits.

5. Obtain valid and informed consent and document in participant's health records.

6. Identify participant by surname, first name and date of birth using open questions checking against NDIS number.

7. Establish that the participant has no known allergies.

8. Clarify if the participant requires a formal chaperone.

9. Check suppository to be administered against Medicines Administration chart or, if at discretion of the Health Practitioner (and in accordance with policy), document the administration appropriately.

10. Ensure Medicines Administration chart specifies:
    - participant's full name
    - participant's date of birth
    - Prescriber's signature and date prescribed
    - Name of suppository/enema to be administered
    - Dose to be administered
    - Route of administration
    - participant's allergy status

11. Allow participant to empty bladder first if required.

12. Ensure a bedpan, commode or toilet is readily available.

13. Decontaminate hands as per *Infection Control Policy and Procedure* (Hand Hygiene Procedure) and apply gloves and apron (single use nonsterile disposable).

14. Open the packet/suppository and lubricate the suppository with lubricating gel or water according to the manufacturer's instructions.

15. Insert the suppository into the rectum, ensuring that it is placed against the bowel wall.

16. Observe the participant throughout the procedure:
    STOP:
    - If anal area is bleeding
    - If the participant asks you to
    - If participant is showing signs of autonomic dysreflexia.

17. When completed procedure, clean residual lubricating gel from the perineal area.

18. Ensure participant is comfortable and ask them to retain the suppository for 20 minutes, or until they are no longer able to do so.

19. Ensure participant has access to commode/bedpan/toilet.

20. Dispose of all equipment and PPE as per Australian Quality Care's *Management of Waste Policy and Procedure*, remove gloves and apron and decontaminate hands as per Australian Quality Care's *Infection Prevention and Control Policy and Procedure.*

21. Document the procedure carried out, and the outcome of the procedure in the participant's health record.

22. If any abnormality is found, escalate to the Registered Nurse who can ensure an appropriate referral is made to the relevant Health Practitioner.

Complex Bowel Care Procedures Appendix 7: Digital Rectal Stimulation in Adults

Equipment Required

Equipment required:

- Bed pan
- Gloves
- Apron
- Lubricating gel
- Disposable protective pad.

Procedure

1. Obtain careful history from participant prior to examination, including establishing whether participant has any known allergies.

2. Ensure participant is introduced to staff involved in the procedure.

3. Explain each step of the procedure to the participant, including potential risks and complications, and the benefits.

4. Obtain valid and informed consent and document in participant's health records.

5. Identify participant by surname, first name and date of birth using open questions checking against NDIS number.

6. Clarify if the participant requires a formal chaperone.

7. Ask the participant if they wish to use the toilet prior to undertaking the procedure.

8. Ensure the bedpan/commode/toilet is readily available.

9. Perform physical observations required according to whether an acute intervention or regular ongoing intervention and observe for signs and symptoms of Autonomic Dysreflexia in Spinal cord injured participants.

10. If at any time the heart rate drops, rhythm changes or signs of Autonomic Dysreflexia – **STOP** the procedure.

11. Assist the participant to lie on the left side, with knees drawn to the abdomen, and buttocks near the edge of the bed.

12. Place a disposable protective pad underneath the participant's hips and buttocks and cover area to be exposed.

13. Place lubricating gel onto gloved finger and anus.

14. Inform the participant of imminent procedure.

15. Gently insert single gloved finger into the rectum up to the 2nd joint only. Turn the finger so that the padded area is in contact with the bowel wall throughout.

16. Gently rotate in a clockwise direction 6-8 times for approximately 10 seconds, or until relaxation of the sphincter felt.

17. Observe the participant throughout the procedure:
    STOP:
    - If in discomfort
    - If perianal area bleeding
    - If participant asks you to
    - If there are signs and symptoms of Autonomic Dysreflexia.

18. Gently remove finger and await reflex evacuation of the stool.

19. If reflex activity does not occur, repeat every 5-10 minutes until rectum is empty or activity ceases. Do not repeat more than three times if reflex activity does not occur.

20. When completed procedure, clean the peri anal area.

21. Dispose of all equipment as per Australian Quality Care's *Management of Waste Policy and Procedur*e, remove gloves and apron and decontaminate hands as per the Australian Quality Care's *Infection Prevention and Control Policy and Procedure*.

22. Document all actions and outcomes in participant's health records.

23. If any abnormality is found, escalate to the Registered Nurse who can ensure an appropriate referral is made to the relevant Health Practitioner.

Complex Bowel Care Procedures
Appendix 8: Management of Stomas

Definition of Terms

Colostomy – large intestine or bowel

Ileostomy – small intestine or bowel

Appliances Required

Appliance details:

- Closed pouch
- One piece pouch
- Drainable pouch
- Two-piece pouch
- Base plate & flange.

Procedures

General

1. Follow personal hygiene and infection control procedures.
2. Replace and dispose bags appropriately.
3. Maintain participant's charts/records.
4. Monitor skin condition/keep stoma area clean.

Removing Pouch

1. Slowly remove pouching system.
2. Loosen and lift the edge of the pouching system with one hand and push down on the skin near the skin barrier with the other hand.
3. Use warm water to remove the pouching if required.

Cleaning

1. Use warm water, mild soap, and a washcloth.
2. Rinse well because the residue may keep the skin barrier from sticking and may also cause skin irritation.
3. Remove the paste before you wet the area, use adhesive remover if required.
4. Always dry the skin well before putting on new pouching system.

5. Do Not rub too hard as the stoma has no nerve endings. Therefore, use a gentle touch when cleaning around the stoma, do not scrub.

6. Do not use alcohol or any other harsh chemicals to clean the skin or stoma.

7. Do not use moistened wipes, baby wipes or towelettes that contain lanolin or other oils, these can interfere with the skin barrier sticking and may irritate the skin.

8. Do not apply powders or creams to the skin around the stoma because they can keep the skin barrier from sticking.

9. Water won't hurt the stoma or go inside. If the water pressure is strong do not let it hit the stoma directly. Only use a gentle spray of water on the stoma.

10. Observe and report any abnormal changes:
    - Stoma colour
        a. Normal – pink/red/warm to touch.
        b. Abnormal– Black/dusky/pale/sloughy.
    - Skin
        a. Normal – Skin surrounding the stoma should be intact.
        b. Abnormal – Any soreness/ulceration/inflammation or broken skin.
    - Oedema (swelling)
        a. Abnormal – Any sudden or unexplained swelling of the stoma.
    - Bleeding Stoma
        a. Normal – A slight smear of blood on the wipe when washing or drying the stoma.
        b. Abnormal – Excessive bleeding when cleaning the stoma/blood in the pouch/bleeding from inside the stoma.

Possible Complications

Be aware of and alert to possible complications such as:

- faecal blockages
- bleeding stoma
- abnormal skin around stoma
- signs of infections.

If any of the above complications are noticed - report to the Registered Nurse who can refer to the relevant Health Practitioner.

Document Control

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