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COMPLEX BOWEL CARE SUPPORT PLAN

Identified need for support	Goals	Interventions
Bowel Support Secondary to: ☐ Constipation ☐ Faecal incontinence ☐ Faecal impaction ☐ Bowel perforation ☐ Other: ____________________ **Risk of impaired skin integrity related to:** ☐ Faecal overflow ☐ Perforation ☐ Infection ☐ Perianal skin irritation **Support needed as a result of:** ☐ Bowel or bladder cancer ☐ Obstruction or blockage of the bowel/bladder ☐ Diverticular disease ☐ ABI (Acquired Brain Injury) ☐ Cerebral Palsy with GMF (Gross Motor Function) Level 3, 4, or 5 ☐ Spinal injury ☐ Neurological conditions, e.g., stroke, autism, and where support involves non-routine PRN treatment ☐ Other: ____________________	☐ To maintain bowel regularity ☐ To maintain client comfort and hygiene ☐ To maintain skin integrity from irritation related to faecal incontinence, and stoma appliance ☐ Colostomy ☐ Ileostomy *Usually surgically performed due to problems with the lower bowel and to create new pathways for stools to pass. The anus is no longer where stools leave the body. Related conditions include certain illnesses, injuries or other problems with the digestive tract including Crohn's disease, diverticulitis, intestinal obstruction, which is blockage in the large bowel, colon cancer.* ☐ Other: ____________________ Who to contact with questions or concerns: ____________________________	☐ Encourage regular toileting to minimise physical and/or medication intervention ☐ Identify and record normal stool appearance ☐ Observe and record bowel habits ☐ Identify symptoms that require actions e.g., overflow, impaction, perforation, infection, discomfort/pain ☐ Timing of intervention (how long before action is taken) e.g., if diarrhoea over 2 days and constipation over 4 days ____________________________ ____________________________ ____________________________. **Prescribed Actions:** ☐ Massaging of abdomen ☐ Administer laxative ☐ Administer enemas or suppositories ☐ Administer non-routine PRN medications ☐ Digital rectal stimulation in adults ☐ Record time and outcome of actions taken **Promote:** ☐ 2 litres of water daily or as clinically appropriate ☐ Well-balanced diet and dietary intake (liaise with dietitian) ☐ Physical activity as able/capable

Evidenced by: ☐ Medical Notes ☐ Health Care Directive Date: ______________________		☐ Referral to physiotherapist or relevant Health Practitioner if immobile **Observe for:** ☐ Loss of appetite ☐ Dehydration ☐ Discomfort/pain ☐ Frequency of bowel movement ☐ Consistency of stool ☐ Colour of stool ☐ Mucus, blood, pus, excessive fat, undigested tablets ☐ Offensive odour

Stoma Care

1. Follow personal hygiene and infection control requirements
2. Replace and dispose of bags appropriately
3. Maintain charts and records
4. Monitor skin condition and keep stoma area clean
5. To clean:
    - Use warm water, mild soap, and a washcloth
    - Rinse well because the residue may keep the skin barrier from sticking and may also cause skin irritation
    - Remove the paste before wetting the area. Use adhesive remover if required
    - Always dry the skin well before putting on the new pouching system
    - Do not rub too hard as the stoma has no nerve endings
    - Do not use alcohol or any other harsh chemicals to clean the skin or stoma
    - 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
    - Do not apply powders or creams to the skin around the stoma because they can keep the skin barrier from sticking
    - Only use a gentle spray of water on the stoma
    - Observe and report any abnormal changes, infection, or inflammation to the relevant health practitioner.

Other participants specific interventions:

Risk/Response:

- ☐ Autonomic dysreflexia
- ☐ Faecal blockages
- ☐ Constipation/faecal impaction
- ☐ Diarrhoea/faecal incontinence
- ☐ Signs of infection
- ☐ Rectal bleeding
- ☐ Perforation

Refer to General Practitioner if any of the above risks occur to ensure participants well-being.

Prepared by:		
Position Title:		
Signature:		Date:
Reviewed and Approved by:		
General Practitioner Name:		
General Practitioner Signature:		Date:
Health Professional Name:		
Health Professional Signature:		Date:

Agreement

By signing this Support Plan, I agree that I have been involved in the development of my plan. I agree and consent to the care and interventions of this Complex Bowel Care Support Plan.

Participant/Representative Name:		
Participant/Representative Signature:		Date:
Company Representative Name:		
Company Representative Signature:		Date:

Communication / Copy of Support Plan	
Copy of Support Plan given to:	☐ Participant ☐ Health Professional ☐ Health Practitioner ☐ Other:

Progress Chart

Date	Change to Identified Need / New Problem	Intervention	Name / Signature / Delegation

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Evaluation Chart

Date	Evaluation	Name / Signature / Delegation

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Complex Bowel Care Directive

General Practitioner, Health Practitioner, Registered Nurse (RN) or Other Health Professional

	Date:	

Diagnosis/Medical History
Specific Care Orders/Treatment Plan
Risks and Complications

Plan Review Frequency	

Informed Consent Obtained	☐ Yes ☐ No
If NO, state details:	

Authorisations

Medical Practitioner Name			
Medical Practitioner Signature		**Date**	
Client Name			
Client Signature		**Date**	

Document Control

Version No.	Issue Date	Document Owner
1	19/12/2024	Elizabeth Bradshaw
Version History		
Version No.	Review Date	Revision Description