PROTOCOL FOR: **Bowel Management**

SUPPORTIVE DATA: A variety of patient groups experience difficulty in maintaining adequate bowel function. These groups include patients with: spinal cord injuries, partial paralysis, degenerative nerve disease, post CVA and other chronic illnesses which contribute to limited sensation and mobility. The medication administration record should also be reviewed for medications that are known to cause changes in bowel function (diarrhea or constipation) Assessment, monitoring and maintenance of adequate bowel function are the responsibility of nursing.

DESIRED PATIENT OUTCOMES:

1. Patient will be continent with predictable and regular bowel movements.

2. Patient will verbalize/demonstrate measures to maintain an adequate bowel pattern.

CLINICAL ASSESSMENT/ AND CARE:

1. Assess usual bowel pattern, motor-sensory function, and use of laxatives, enemas, suppositories, and nutritional intake pattern.

2. Assess bowel sounds, patient report of urge to defecate, and abdominal distention.

3. Initiate bowel program:

   a. Encourage adequate amounts of fluids – at least 48oz or 6-8 glasses of fluid daily or per LIP order.

   b. Include plenty of fiber in the diet. Fiber can be obtained from fresh fruits and vegetables, whole grain breads and cereals per LIP order.

   c. Encourage physical activity to promote muscle tone and bowel motility as tolerated per LIP order.

   d. Utilize stool softeners, laxatives, enemas and suppositories as needed per LIP order.

   e. Establish a regular time and schedule for emptying the bowels. Individualize a schedule based on patient’s pre-hospital pattern, and current amount and frequency of stools per day.

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f. Encourage patient to respond to sensation to defecate, especially after meals.

4. Monitor and document status of bowels during hospital stay, i.e. frequency, consistency and time of stools.

5. Consider a consultation with a registered dietician for patients whose diagnosis contributes to limited sensation and mobility.

DOCUMENTATION:

1. Document assessments and interventions on the unit flow sheet, database, medication administration record and Infusion Record.

2. Document patient education related to bowel management on the Patient and Family Teaching Record.

APPROVAL: Medical-Surgical Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 1/92

REVISION DATE: 5/03, 8/05, 11/05