fraserhealth Surrey Memorial Hospital

ADULT BOWEL CARE PROTOCOL - Medicine
PHYSICIAN ORDER FORM - *DRAFT*

Date: _____
(dd/mm/yyyy)

Allergies: _____
_____
_____

Prevention and Management of Constipation in Adults

Doctor's Orders (Physician to indicate by check mark or cross off interventions and medications in each section *BEFORE* signing.) Nursing to implement the items indicated by the physician.

Daily Prevention and Maintenance	☐ Pureed dried fruit 25 grams PO bid *(except for diabetic and renal patients)* ☐ High fibre diet (25 to 35 grams fibre) *with minimum 1500 mL fluid intake (except for bedridden patients)* ☐ Consults (i.e. Dietitian, PT, Pharmacy) _____ ☐ Sennosides **12 mg** PO at bedtime *OR* ☐ Sennosides **24 mg** PO at bedtime } **Recommended for patient on opioid analgesics**
Day 3 (No BM) *In addition to daily Prevention and Maintenance*	■ Sennosides 12 mg PO at bedtime
Day 4 (No BM) *In addition to daily Prevention and Maintenance*	■ One bisacodyl 10 mg suppository +/- one glycerin suppository per rectum in AM *(preferably 30 minutes after breakfast)* *If above Suppository not effective give:* ■ Lactulose 30 mL PO in AM *AND* ■ Sennosides 24 mg PO at bedtime
Day 5 (No BM) *In addition to daily Prevention and Maintenance*	**Rectal check completed with soft stool present in rectum give:** ■ Fleet enema 120 mL PR in AM *OR* MICROLAX enema 5 mL 1 or 2 PR in AM *If no stool in rectum give:* ■ Lactulose 30 mL PO in AM *AND* ■ Sennosides 24 mg PO at bedtime
Day 6 (No BM) *In addition to daily Prevention and Maintenance*	**Rectal check with hard stool present in rectum give:** ■ MICROLAX enema 5 mL 1 or 2 rectally *If NO results disimpaction indicated give:* ■ Mineral oil enema prior to disimpaction followed by MICROLAX enema if needed to clear fecal mass **If NO stool present in rectum assess client for abdominal pain, distension and nausea and vomiting – NOTIFY PHYSICIAN** ☐ Flat plate of abdomen

If stool consistency changes to "diarrhea" on any day, discontinue protocol. Reassess and discuss with Physician the need for adjustment of this protocol.

Physician Signature: _____

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ADULT BOWEL ASSESSMENT FORM

Complete Initial Assessment History (Complete on initiation at Bowel Care Protocol) DATE COMPLETED: _____ INITIAL: _____ *(dd/mm/yyyy)*	Date of last BM: _____ *(dd/mm/yyyy)* Transcribe to *Adult Bowel Care Medication Administration Record*

BOWEL PATTERN:	*Amount	**Consistency	***Frequency (# BM per week)	Color	Associated Factors (e.g., time of day, equipment used)
Lifelong Bowel Pattern					
Recent Bowel Pattern					

What Laxatives do you use? (dose/frequency)	Do you strain when you have a bowel movement? ❑ Yes ❑ No

What else do you do to help you move your bowels?

Current fluid intake / 24 hours:	❑ Less than 6 cups of fluid	❑ Greater than 6 cups of fluid	❑ Greater than 8 cups of fluid

Current Nutrition intake	❑ Liquid only ❑ Tube Feed	❑ High fibre diet (whole grains, fruits, vegetables, cereals)	❑ Minimal roughage (fruits and vegetables)

*KEY:	*Amount:	S = < ½ cup	M = ½ to 1 cup	L = 1 to 2 cups	XL = > 2 cups
	** Consistency:	W = Watery	L = Loose	F = Formed	H = Hard

***Frequency: Continuous/oozing, or Average number of stools per week