






BOWEL MANAGEMENT














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Introduction

All staff should have a positive approach to the maintenance and promotion of continence, which must be planned to meet the individual's personal needs. Incontinence should not be viewed as an inevitable consequence of old age, as many elderly people are continent and should be encouraged and supported to remain so. The aim of bowel management is to:

-  *To provide relief of distress resulting from constipation or diarrhoea,*
-  *To assess the individual's bowel needs through appropriate history and relevant Health professional input*
-  *To develop a care plan with the individual to: improve bowel control, reduce pain and improve quality of life*
-  *To monitor the effects of bowel management and adjust accordingly within the care plan*

Procedure

-  Ensure that all care involves the individual and is directed towards maintaining dignity
-  Achieve and maintain a pattern of elimination that maximises the individual's needs
-  Offer education and support to prevent future problems arising
-  Provide appropriate resources to meet the individual's needs
-  Encourage individual choice
-  Certain foods are known to stimulate gut reactions in general, and in those with bowel incontinence, or accidental bowel leakage (ABL), eating too much of these might provoke unwanted reactions.
-  For example, meals that are too large or high in fat, fried foods, coffee, caffeine, or alcohol may provoke symptoms of abdominal cramps and diarrhea.
-  Eating too much of some types of sugar that are poorly absorbed by the bowel can also cause cramping or diarrhea (e.g., sorbitol, commonly used as a sweetener in many dietetic foods, candies, and gums; and fructose, also used as a sweetener and found naturally in honey as well as some fruits).
-  Some foods are gas producing (e.g., beans, cabbage, legumes, cauliflower, broccoli, lentils, Brussels sprouts, raisins, onions, bagels) and eating too much may cause increased gaseousness.
-  Other foods can be odor forming with gas. These foods may include: alcohol, asparagus, beans, cabbage, chicken, coffee, cucumbers, dairy products, eggs, fish, garlic, nuts, onions, prunes, radishes, and highly seasoned foods.
-  The influence of diet on incontinence is unique to each individual and there is no generalised dietary advice that will work for everyone.
-  The GP or continence nurse may ask for a brief dietary history and with a 2–3-week diary of dietary intake, symptoms, and any associated factors (e.g., daily obligations, stressors, poor sleep, medications) can help identify dietary and/or other factors that may impact symptoms of incontinence, or ABL.
-  A health professional (e.g.GP, continence nurse or registered dietician) can provide dietary guidance while assessing individual circumstances and helping make sure that nutritional needs are being met through a balanced diet, and healthy eating habits.



Prescribed medications can help improve diarrhea and constipation or assist in the development of a more predictable bowel pattern. Examples include antidiarrheal medications, laxatives, fibre supplements, and stool softeners.

1. **Antidiarrheal Agents:** These are agents such as loperamide and diphenoxylate and can be effective in decreasing bowel movement frequency, improving stool form by enhancing intestinal water and ion absorption, and increasing anal sphincter tone at rest. These physiologic actions seem to explain the improvement in diarrhoea, urgency, and faecal soiling observed in individuals who use these products. These medications do not typically relieve abdominal pain and may cause constipation.

2. **Laxatives:** This is a medication that increases bowel function. There are four main classes of laxatives: fibre, osmotic laxatives, stimulant laxatives, and emollients.



Osmotic laxatives - Sodium, Potassium and Magnesium salts are poorly absorbed compounds that cause an influx of water into the small intestine and colon, thereby increasing stool bulk.



Stimulant laxatives – Sodium Picosulphate and Glycerin have a direct stimulating effect on the network of nerves in the large intestine and reduce absorption of water and electrolytes from gastrointestinal contents. Stimulant laxatives take effect within hours of ingestion.



Emollients act as stool softeners- **synthetic surface active agents, liquid paraffin**



Fibre- bulk producers – dietary fibre, Mucilaginous Polysaccharides. The type of fibre – either soluble (in water) or insoluble – can make a difference. Soluble fibre dissolves in water and forms a gel when water is added to it. Insoluble fibre absorbs liquid and adds bulk to stool.

When adding fibre to the diet, it is best to do so slowly over a period of weeks. If gas or distention occur, try reducing the dose of fibre and reducing consumption of gas-producing foods, such as beans, cabbage, legumes (e.g., peas, peanuts, soybeans), apples, grapes, and raisins.

3. **Faecal Incontinence:** This requires to be treated sympathetically and sensitively; individuals with this problem should not feel apprehensive. Observation by nursing or care staff should be highlighted as an area of importance, since an individual with this problem often exhibits behavioural changes when bowel evacuation is imminent.

4. **Bowel training programs generally take these three basic principles into account:**



Improve consistency of stool.



Establish a regular time for elimination.



Stimulate emptying on a routine basis.

The first is always to rule out any fecal impaction. This needs to be remedied or attempts to train the bowel will be met with frustration.







a) **Normal stool consistency:** Optimal goal for stool consistency is a formed, soft stool. Hard stools are difficult to evacuate and leakage is less likely if stools are not liquidy. This is obtained by eating well-balanced, regularly timed meals which are high in fibre. Dietary fibre refers to the parts of the food that humans are unable to digest. This includes: whole grains, legumes, fresh fruits, and vegetables. Fibre adds bulk to the stool, eliminates excess fluids, and promotes more frequent and regular movements. When fibre is increased, it is also important to drink adequate fluids. If fluid intake is inadequate the stool becomes hard because of the amount of water that is absorbed by the large intestine. The amount of fibre and fluids necessary for bowel regulation varies for everyone. Identifying any food intolerance is also helpful in reducing symptoms. Dietitians are experts in evaluating and adjusting diets and should be involved with the individuals care plan

b) **Establish a regular time for elimination:** A bowel training program is most effective when done at the same time each day. The goal is to establish a routine and predictable time for elimination. When choosing an appropriate time, consider with the individual their past pattern of bowel elimination and their present lifestyle. The time should be convenient so it is not rushed. For example, planning for after meals allows the individual to take advantage

of the gastrocolic reflex (wave-like movements which propel the fecal material through the colon to the rectum) which occurs 20 - 30 minutes after a meal.

- c) **Stimulate emptying on a regular basis:** Usually a stimulus of some kind may be needed to help you empty your rectum. The stimulus will vary from individual to individual. The stimulus works by creating peristalsis or wave-like movements of the colon. As mentioned previously, a meal or hot drink may be an effective stimulus for one person. Others may need to use suppositories, enemas, or laxatives (use only under the advice of your physician) or a combination of the above. The least stimulus that is effective in promoting evacuation is recommended.

5. Practicalities













-  Privacy, dignity, and independence must be encouraged.
-  All rooms should be within five metres of a toilet facility to allow quick access when required. Each room should be provided with a chair commode if required, which should be available for use by the individual; this is cleaned as necessary.
-  In bathrooms and toilets, the floor covering is of a heavy duty, non-slip cushion flooring material; this is warm to the touch and sealed at its edges so that seepage under the material will not occur; the covering is easily cleanable and does not retain odours.
-  Most bathrooms and toilet floors are covered by a non-slip, sealed vinyl material; others are carpeted and these areas should be cleaned daily or as required.
-  Cleaning materials are constantly evaluated as to their effectiveness and efficiency. Any changes should be carried out and used in accordance with the appropriate COSHH regulations.
-  Furniture is cleaned regularly to ensure cleanliness and an odour-free environment. Lounge furniture should be cleaned at night when individuals are sleeping.











Further Guidance.

Faecal incontinence in adults: management. Clinical guideline [CG49] Published date: June 2007

Enema Administration Procedure

















An enema is the administration of a substance in liquid form into the rectum either to aid bowel evacuation or to administer medication. Enema administration is performed by a practitioner with the appropriate knowledge and skills and where it is within their professional practice to carry out this procedure

-  Explain and discuss the procedure with the individual to ensure they understand what is going to happen and give their consent
-  Wash hands and ensure privacy for the individual
-  Encourage the individual to empty their bladder as a full bladder can cause discomfort during the procedure
-  Ensure a commode or toilet is easily accessible and close by.
-  Warm the enema in a bowl or jug of hot water
-  Assist the individual to lay on their left side with knees flexed and the upper knee higher than the lower one. Make sure their buttocks are near the edge of the bed
-  Place a disposable sheet under the buttocks and bottoms
-  Wash hands again and put on disposable gloves
-  Lubricate the nozzle of the enema with some lubricating gel on a piece of gauze
-  Expel excessive air in the enema and then introduce the tube slowly into the anal canal while separating the buttocks. This is to prevent unnecessary discomfort to the individual.
-  Slowly introduce the nozzle and tube to a depth of 10.0-12.5cm to ensure it is in the rectum
-  If a retention enema is being used introduce the liquid slowly and ask the individual to stay on the bed with the foot of the bed elevated by 45 degrees for as long as prescribed. (the slower the rate of which the fluid is introduced the less pressure is exerted on the intestinal wall)

-  If an evacuant enema is being used, introduce the fluid slowly by rolling the pack from the bottom to the top to prevent backflow, until the pack is empty or the solution is finished. The faster the rate of flow the greater the pressure on the rectal walls. Distension and irritation of the bowel wall will produce a strong peristalsis which is sufficient to empty the lower bowel.
-  If using a funnel and rectal tube adjust the height of the funnel to regulate the flow
-  Clamp the tube before all the liquid has run in to avoid air entering the rectum and causing discomfort
-  Slowly withdraw the nozzle or tube to avoid reflex emptying of the rectum
-  Dry the perineal area with gauze swabs and ask the individual to retain the enema for 10 – 15 minutes before evacuating the bowel
-  Ensure the individual has a call bell and is near the commode or toilet and toilet tissue
-  Remove and dispose of equipment, gloves, and apron in clinical waste bags
-  Wash hands
-  Complete all necessary records and charts to include consistency and amount of faeces produced using the Bristol Stool Chart
-  Observe the individual for any adverse reaction and assist the individual as required when the procedure is complete.

Suppository Administration Procedure

A suppository is a solid or semi-solid, bullet shaped pellet that is prepared by mixing a medication with a wax-like substance that melts once inserted into the rectum. Suppository use may be indicated under such circumstances as; emptying the bowel before surgery or to relieve constipation. To introduce medication or soothe and treat haemorrhoids

-  Explain and discuss the procedure with the individual to ensure they understand what is going to happen and give their consent
-  Wash hands and ensure privacy for the individual
-  Ensure a commode or toilet is easily accessible and close by.
-  Assist the individual to lay on their left side with knees flexed and the upper knee higher than the lower one. Make sure their buttocks are near the edge of the bed
-  Place a disposable sheet under the buttocks and bottom
-  Wash hands again and put on disposable gloves
-  Lubricate the blunt end of the suppository if it's being used to obtain systemic action with a gauze square and lubricant.
-  Separate the individual's buttocks and insert the suppository blunt end first advancing it for about 2-4cm. repeat the procedure if a second suppository is prescribed.
-  Then clean the perineal area with gauze swabs
-  Ask the individual to retain the suppository for 20 mins or until no longer able to do so
-  Ensure the individual has a call bell and is near the commode or toilet and toilet tissue
-  If a medicated suppository is given remind the individual that the aim is not to stimulate evacuation and to retain the suppository for at least 20 minutes or longer if possible.
-  Remove and dispose of equipment, gloves, and apron in clinical waste bags
-  Wash hands
-  Complete all necessary records and charts to include consistency and amount of faeces produced using the Bristol Stool Chart
-  Observe the individual for any adverse reaction and assist the individual as required when the procedure is complete.