2021

8848
Disability Services

BOWEL CARE PROCEDURE

8848 DISABILITY SERVICES

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What are the Procedures?

1.1 Monitoring and Supporting Bowel Health

- Support workers do not diagnose health issues. However, they are required to monitor and report regularly on the health and wellbeing of the people they support, including bowel health, where required.
- Not every customer requires support with bowel health. 8848 Disability Services supports people to live as independently as possible. Due to the sensitive nature of supporting people with bowel care, consent must be obtained from the customer beforehand.
- If a Bowel Care Management Plan (see Section 1.2) is required, the customer and / or person responsible must be included in the development of the plan in consultation with the healthcare professional.
- If appropriate, staff are to learn about the customer's usual bowel habit so they can identify when there is a change.
- A Bowel Chart and the Bristol Stool Chart are used as the standard measure for recording bowel habits. These can also help staff know when medical intervention is required.
- Use the Bowel Chart to record the customer's bowel habits every shift and the Bristol Stool Chart to describe the stool volume and consistency (**Figure 1**).
- When the Bowel Chart shows that the person's bowel habit has changed, this should be referred to a healthcare professional for further investigation.

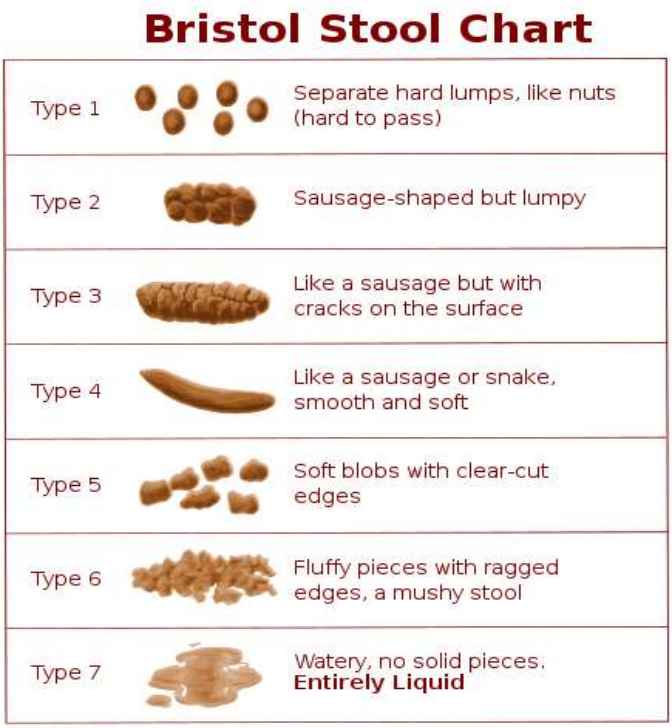


Figure 1 – Bristol Stool Chart.

- Talk to the customer about the observed change in bowel habit in case there has been some variation in the customer's circumstances that might explain the change, for example, new medication, different diet or recent illness.

1.2 Bowel Care Management Plan

- A Bowel Care Management Plan is required for every customer who is at significant risk of bowel related complications and where support workers are required to perform healthcare procedures to support the customer with their bowel care. For example:
    - Giving non-routine / as required (PRN) medication for bowel care.
    - Supporting customers with a colostomy bag.
    - Giving routine bowel medication.
    - Giving routine suppositories.
- The Bowel Care Management Plan must be developed and reviewed every 12 months by a health practitioner. The plan must be reviewed sooner if the customer's needs change.

- Minimum plan requirements include:
    - information on normal stool appearance for the individual
    - how to identify symptoms that require action
    - timing of intervention (how long before action is taken)
    - the action required; and
    - record keeping instructions

- When the customer is experiencing problems with bowel functions, support workers must understand:
    - the issues that affect bowel function, especially for the person they support
    - signs and symptoms of bowel problems
    - why they need to document bowel patterns to detect changes and
    - the importance of involving health professionals to assess the causes of bowel dysfunction, especially for people with complex health conditions

1.3 Bowel Dysfunction

- Bowel dysfunction is described as difficulty passing faeces (also known as stools), or keeping faeces contained in the bowel, or passing faeces that is not considered to be 'normal' in consistency.
- Bowel dysfunction is classified under three headings:
    - Constipation and poor bowel emptying
    - Diarrhoea
    - Faecal Incontinence

1.3.1 Constipation

- Constipation causes discomfort and affects quality of life.
- It is described as the difficulty pass faeces or experiencing pain when passing faeces or passing faeces infrequently.
- Poor bowel emptying occurs for various reasons and can cause constipation.
- Constipation is potentially life threatening if it goes untreated.
- Constipation can be caused by disorders affecting digestion and bowel function, psychological or neurological conditions or a bowel that is not necessarily diseased, but does not function as well as it should.
- Constipation may be associated with low mobility, an inadequate diet, the slow movement of faeces through the bowel or an abnormality of the muscles involved in emptying the bowel (pelvic floor muscles).

1.3.2 Diarrhoea

- Diarrhoea is loose watery faeces and is usually frequent.
- **Figure 1** provides an image of the Bristol Stool Chart for descriptions of different types of faeces.
- Diarrhoea can be acute and short lived, for example with food poisoning or a bowel infection and may easily be spread to other people.
- Diarrhoea can be a chronic condition as a result of inflammatory bowel disease, irritable bowel syndrome or coeliac disease. Diarrhoea may also be caused by food allergies, a side effect of certain medications, radiation therapy, diabetes or an overuse of laxatives.
- Diarrhoea can be observed by a support worker but is difficult to identify if the customer independently uses the toilet and does not report it. It may be associated with stomach bloating and pain and be accompanied by vomiting.
    - An outbreak of diarrhoea must be reported to the NSW Ministry of Health, Public Health Unit. An outbreak occurs when diarrhoea affects two or more people in the same house or facility, even when the cause is unknown.
    - Follow this link to your nearest Public Health Unit: http://www.health.nsw.gov.au/Infectious/Pages/phus.aspx

1.3.3 Faecal Incontinence

- Faecal incontinence is uncontrolled passing of faeces and can create social or hygiene problems for the person.
- The person may not always be aware that this is happening.
- Signs of **faecal incontinence** include the person's inability to get to the toilet in time and repeated occasions of soiled clothing.

- Faecal incontinence can be caused by poor muscle control or muscle damage after surgery or child birth, an infection or an inflammation of the bowel, irritable bowel syndrome or stress from haemorrhoids or other conditions involving the rectum or sphincter muscle. It may also be developmental.
- Nerve damage or disease caused by a spinal chord injury, multiple sclerosis or spina bifida can result in faecal incontinence, as can lifestyle and environment factors. Some examples include poor toilet facilities, diet and lack of independence to move around or manage clothing.
- A person with dementia may suffer loss of memory and skills and may experience incontinence.

1.4 Signs and Symptoms

There are a number of signs of **constipation** including:

- straining or pain when trying to pass faeces
- lumpy or hard faeces
- feeling that the rectum is not completely empty
- having fewer than three bowel motions per week
- passing liquid stools (overflow) but having symptoms of constipation (This is sometimes misunderstood and staff may think this is Diarrhoea)
- behaviour that is unusual for the person
- it may be associated with stomach bloating and pain and be accompanied by vomiting

1.5 Responding to Bowel Concerns

All Services

- Report the changes to a line manager / family and / or person responsible.
- Following a diagnosis and recommendations by the GP, continue to monitor the customer's bowel habit.
- If the GP has developed a Bowel Care Management Plan, follow the plan and record all motions in the Bowel Chart.

Bowel Care Procedures

Housing and Supported Independent Living Services

- Take the customer's Bowel Chart, Medication Chart and Healthcare Summary Plan to the GP appointment. The GP and customer will agree on a plan of action.
- Take the customer back to the GP if there has not been a change within the specified timeframe written in the Bowel Care Management Plan.

1.5.1 Immediate Medical Treatment

- If any of the following symptoms are present, the customer should be supported to attend the GP or local hospital:
    - vomiting blood or faecal matter
    - diarrhoea and / or vomiting that is more than a one-off event
    - bleeding from the bowel
    - fresh (red) or old (black) blood in faeces
    - unusual pain before, during or after a bowel motion
    - presence of faecal odour on the person's breath
- Black faeces occur when a person is taking iron supplements or may occur due to diet (liquorish, beetroot). Take care not to confuse it with old blood in faeces which is also black.

1.5.2 Health Professionals

- In Housing and Supported Independent Living Services, support workers are responsible for supporting the customer to communicate bowel concern to the GP for a diagnosis and treatment.
- The GP may not diagnose bowel dysfunction during the customer's annual health assessment (CHAP Tool) unless the customer or support worker report changes in bowel habits to the GP at that time.
- If the customer needs a Bowel Care Management Plan, the GP develops one in consultation with the customer; input from the support worker may be required.
- Before leaving the GP the customer and / or support worker should be certain that they can easily read and understand how to implement the Bowel Care Management Plan.

For Example: Confirm with the GP what should happen following implementation of the Bowel Care Management Plan and how long it should take for the problem to be resolved. Depending on the diagnosis, the GP may refer the person to another health professional such as a gastroenterologist or a dietitian.

- If the customer's bowel dysfunction is chronic or complex, the GP has access to additional Medicare items for referring the person to a multidisciplinary team for management.
- Staff should refer to 8848 Disability Services's **Chronic Disease Management Procedures** for information about GP Management Plans.
- A health professional may also prescribe bowel retraining after illness or surgery. The person could require special equipment prescribed by an occupational therapist for seating in the best position to empty the bowel.
- The customer may need a nutrition review by a dietitian to establish the right amount of fibre and fluid for promoting bowel health.
- A customer with faecal incontinence may experience skin problems from exposure to faecal fluids and constant cleaning and require a skin care assessment by a continence nurse specialist.
- There are many treatments for bowel dysfunction and health professionals will prescribe different treatments depending on the diagnosis, their preferred approach and other elements of the customer's individual support needs.

1.6 Treatment

Some treatments are administered by a health professional, either a gastroenterologist, GP or a nurse specialist. Other treatments can be administered by the customer and / or support worker.

1.6.1 Medications

- Medications that are safely administered by a customer or support worker are taken either by mouth (orally) or inserted into the rectum (suppositories).
- The method of administration, the dose and frequency is prescribed by the health professional in the customer's Bowel Care Management Plan and Medication Chart.

1.6.2 Rectal Treatments

- Due to the intrusive nature and possibility of injury associated with enemas, it is not recommended that support workers administer enemas other than Microlax.
- Microlax enemas are suitable for children less than three years old and as such, present minimal risk of injury to children or adults during administration.

- Enemas should only be administered by trained 8848 Disability Services support workers for customers in Housing and Supported Independent Living Services. It is not recommended that enemas are provided in any other service unless it is absolutely necessary.
- Digital rectal stimulation involves using a gloved lubricated finger to prompt the bowel to contract and push stool out of the rectum. This stimulation can be repeated several times. While this is not generally a common procedure, it is often used by individuals with neurogenic bowel problems. It can be used by the individual themselves or by nurses or other healthcare professionals or by a support worker under directions of a specific plan and training.
- Where any rectal treatments are prescribed for a customer that are required to be performed by a support worker, the procedure must be approved by Clinical Practice Health to ensure the safest options have been explored, training was provided and appropriate plans are in place. Send email to info@8848disability.com.au with Subject line “Clinical Practice Health”.

1.7 Ostomy Care

- The word **Ostomy** means artificial opening. This opening is created by a surgical procedure and is named by its location.
- Some customers require care for their ostomy. An ostomy pouching system is a prosthetic medical device that provides a means for the collection of waste from a surgically diverted biological system and the creation of a stoma.
- Pouching systems are most commonly associated with colostomies, ileostomies and urostomies.

Colostomy

- The surgically created opening of the colon (large intestine) which results in a stoma. A colostomy is created when a portion of the colon or the rectum is removed and the remaining colon is brought to the abdominal wall. It may further be defined by the portion of the colon involved such as a sigmoid colostomy**.**
- The most common type of ostomy surgery is when the end of the descending or sigmoid colon is brought to the surface of the abdomen. It is usually located on the lower left side of the abdomen.
    - Descending colostomy
    - Transverse colostomy
    - Ascending colostomy

- Faeces and flatus now pass through the stoma, not the anus. With a permanent colostomy, the diseased part of the colon is removed. When a colostomy is temporary, the injured bowel has time to heal and then the temporary colostomy is removed and the bowel is reconnected.

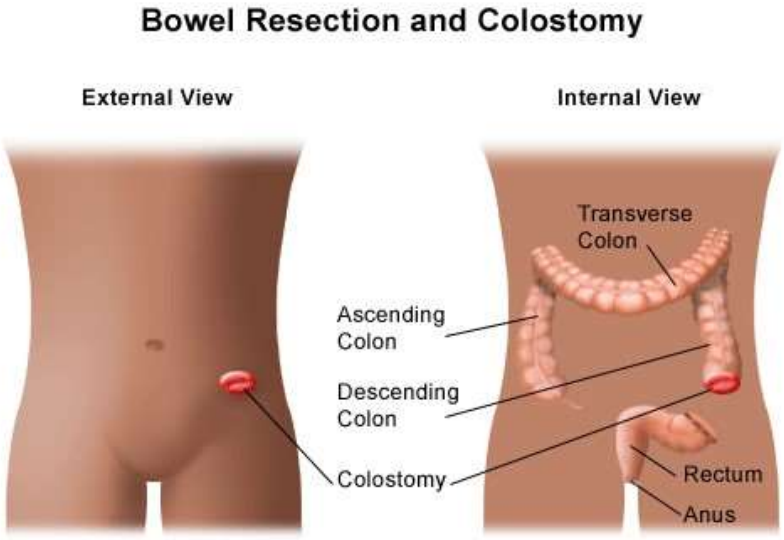
The site of the colostomy depends on the site of the disease or injury. Stool consistency depends on the site. The more colon remaining to absorb water from the stool, the former is the stool. If the site is closer to the end of the colon, the stool has a more liquid consistency.	

Figure 2 – illustration of the colostomy.

Ileostomy

- A surgically created opening in the small intestine, usually at the end of the ileum. The intestine is brought through the abdominal wall to form a stoma. Ileostomies may be temporary or permanent and may involve removal of all or part of the entire colon.
- Water is not absorbed from the faeces as the colon has been removed, hence stools are liquid.

Ostomy Bags

The ostomy bag has an adhesive backing that is applied to the skin. Many bags have a drain at the bottom that closes with clips, clamps or closures. The drain is opened to empty the bag when faeces are present.

The bag is changed every 37 days or when it leaks. Some people will prefer to change the bag daily; however frequent bag changes can damage the skin. Odours can be prevented or minimised by good hygiene, emptying bag frequently, avoiding gas forming foods and putting deodorants in the bag such as charcoal.

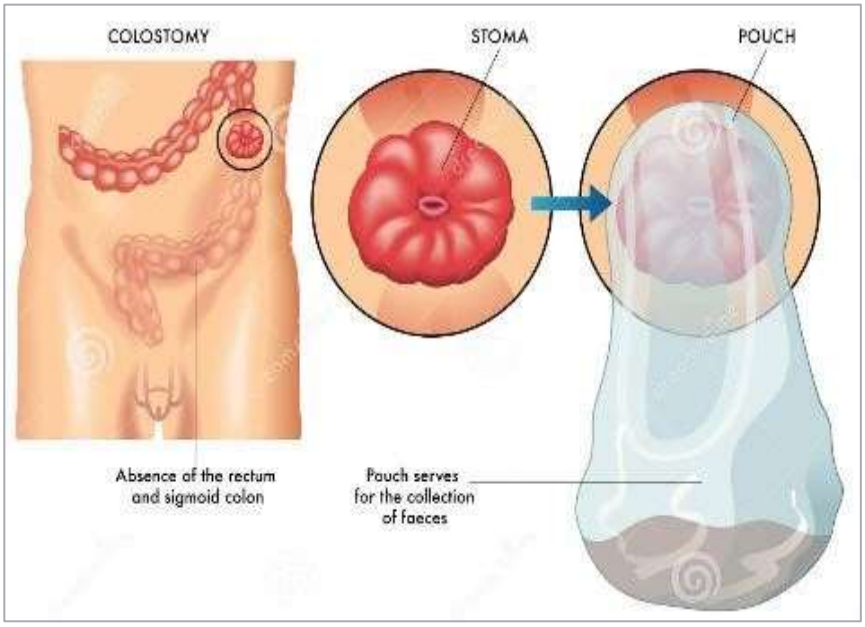


Figure 3 – colostomy, stoma and ostomy pouch.

1.8 Hygiene and Infection Control

- Standard precautions must be followed when supporting customers with bowel care in accordance with 8848 Disability Services's Infection Control Policy and Procedures.

Waste Management

- Where waste is non-infectious it falls outside the definition of clinical waste (HSC Health Services Advisory Committee, 1999).
- **Unless there is visible blood**, incontinence pads and ostomy bags are not considered clinical wastes.
- Royal College of Nursing guidelines (RCN, 1994) recommend that ostomy bags should be emptied into the toilet, then wrapped in newspaper or placed in a disposal bag designed for the purpose and placed in a domestic refuse bin.

- Colostomy bags can either be cut and contents emptied into the toilet before disposal or you can put the used bag with contents and swabs into the disposal bag. Seal the disposal bag and put it into a domestic refuse bin.
- For ileostomy bag or a urostomy bag, empty the contents into the toilet and then place the used bag and any swabs into a disposal bag. Seal the disposal bag; put it into a domestic refuse bin.

1.9 Training

- It is mandatory that support workers receive bowel care training when supporting customers who have ***Complex*** **Bowel Care**. Bowel care training is separated into two sections:

Section 1: Theory:

- Basic anatomy of the digestive system.
- Understanding stool appearance.
- Recognising signs and symptoms.
- Bowel conditions and risk factors.
- Observing and recording bowel habits.

Section 2: Practical

- Relevant healthcare procedures: enema, suppository, ostomy.
- Training in the customer's individualised Bowel Care Management Plan.
- All training requests should be referred to recruitment@8848disability.com.au

Where can I get help?

- Your manager
- Clinical Practice Health Team
- Learning and Development (L&D) Team (Part of recruitment)
- Customer's Health and Wellbeing Page
- Work Health and Safety (WHS) policy

Bowel Care Procedures

What other 8848 Disability Services documents are related?

You may need to refer to these documents for more information:

- Health and Wellbeing Policy and Procedures
- Chronic Disease Management Procedures
- Infection Control Policy and Procedures
- Clinical Procedures Manual

Related Forms

- Bowel Care Management Plan.
- Bowel Data Collection and Bristol Stool Chart.
- Healthcare Summary Form – Brevity
- CHAP tool.

Who is Responsible?	What are they Responsible for?
Operations Executive	Final review and approval of this policy and procedure
National Manager	Maintain this policy, its related procedures and documents.
Regional Manager	• Ensure the policy and procedure is effectively implemented in their services. • Ensure staff follow the policy and procedure.
House Leads	Ensure staff have read and understand the policy and procedure, and have sufficient skills, knowledge and ability to meet the requirements.
All Employees	Follow the requirements of the policy and procedure.

Definitions, Legislation & Standards Compliance

Definitions:

- For other definitions, please refer to 8848 Disability Services Policy Dictionary.

Legislation:

- This policy and procedure was developed in accordance with the National Disability Insurance Scheme (Provider Registration and Practice Standards) Rules 2018.
- For other Legislation and Standards Compliance, refer to the Service Management Policy.

Bowel Care Procedures

Related References

- National Quality and Safeguarding Commission - NDIS Practice Standards: skills descriptors
- Management of lower bowel dysfunction, including DRE and DRF. Royal College of Nursing, 2012
- *Help patients win the constipation battle*. Best practice in the prevention and treatment of constipation in adults under 65 years. Dept. Health and Ageing and Griffith University, Sept 2003
- Management of constipation in older adults. Best Practice Vol 12 Issue 7, 2008
- Impact. Bowel care for the older patient, 2010
- Constipation. Fact Sheets. Westmead Children's Hospital
- *Environment Protection (Industrial Waste Resource) Regulations 2009*. Publication IWRG612.1 — September 2009

Appendix 1 - Anatomy of the Digestive System

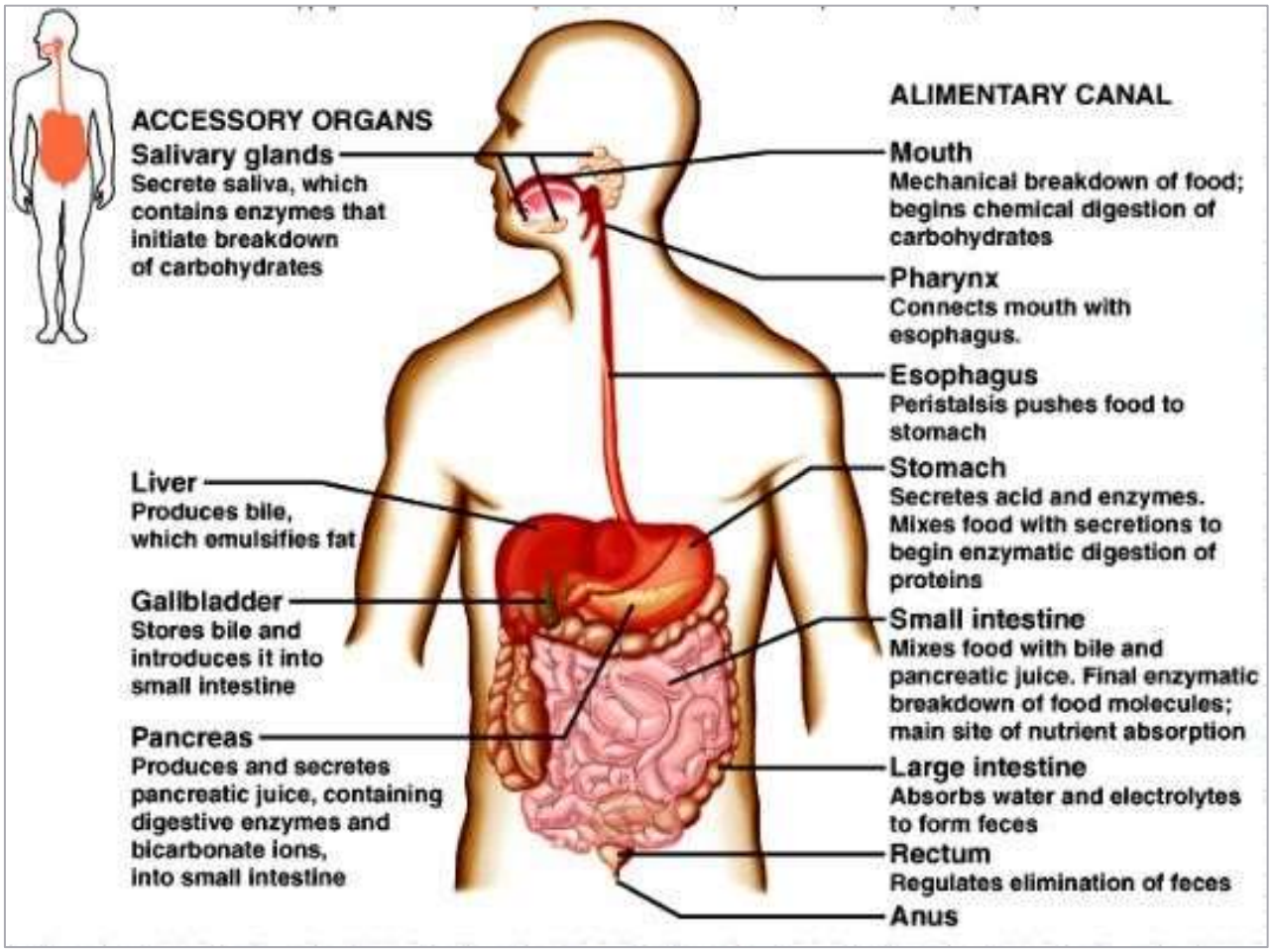


Figure 3 Anatomy of the Digestive System

Alimentary Canal

- The alimentary canal, also called digestive tract, pathway by which food enters the body and solid wastes are expelled. The alimentary canal includes the mouth, pharynx, oesophagus, stomach, small intestine, large intestine, and anus.

Mouth

- The mouth contains the tongue, teeth, hard and soft palates, cheeks, salivary gland ducts and other structures such as taste buds. Food is chewed, shaped and pushed to the back of the mouth as a bolus. The bolus is moved through the mouth to the stomach through swallowing.

Oesophagus

- The oesophagus is a collapsible, muscular tube that is approximately 22-25cms long. The food mixes with mucus and is propelled through the oesophagus by peristaltic waves. The bolus passes through the oesophagus sphincter into the stomach.

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Stomach

- The stomach is divided into 4 sections: the cardia, the fundus, the body and the pylorus. Food and fluids (and some water, alcohol, certain medications) are partially absorbed / digested in the stomach.
- The partially digested foods and fluids is a semi liquid called chyme. Peristaltic waves (the alternating contraction and relaxation of the intestinal muscles) move the chyme moves towards the duodenum. The major function of the stomach is a food reservoir.

Small intestine

- It consists of 3 parts: the duodenum, the jejunum and the ileum. The small intestine is approximately 6-7 meters long and is coiled throughout the abdominal cavity. The chyme is mixed with pancreatic enzymes, bile and intestinal enzymes. Absorption of nutrients and water is the major function of the small intestine.

Large intestine

- The large intestine is approximately 1.5m long. Chyme becomes less fluid and more solid in consistency here after the absorption of fluid (water, all except 90-120ml is absorbed in the large intestine). The remaining solid material is called faeces.
- Food that is consumed is generally passed through the intestinal tract within 24-48 hours (some food can remain in the system for up to 4 days). Because faeces include elements other than food, it is possible to have a bowel movement even if one has had nothing by mouth.
- Faecal material is pushed into the rectum by strong peristalsis. As faeces fill the rectum, the rectal wall becomes distended and these nerve impulses are sent to the brain and spinal cord. These impulses return back which intensify peristalsis. The external anal sphincter is relaxed allowing faeces to enter the anal canal.
- When a person sits on a toilet, the external sphincter relaxes voluntarily, emptying the rectum. This emptying of the rectum is known as defection and the excreted faeces is called stool.

Accessory Organs:

Liver

- Bile aids in the fat digestion and urobilinogen (an end product of bilirubin breakdown) gives faeces its colour.

Gallbladder

- The major function of the gallbladder is to store and concentrate bile. Bile is released into the small intestine when chyme containing high levels of fat enters the duodenum.

Pancreas

- The pancreas lies behind the stomach and is attached to the duodenum by the pancreatic duct. As chyme enters the small intestine, pancreatic secretions are released to aid the digestive process.