# Complex Bowel Care

POLICY AND PROCEDURE

## 1. Purpose

Bowel care is a routine part of personal support. It requires a specialist level of support where the participant is at risk of severe constipation or faecal incontinence.

The Subee Newlake Bowel Care Policy and Procedure is to ensure a high standard of bowel care, including assessment, treatment and management. To ensure safe, competent practice by all support workers undertaking bowel care and reduce risk of complications associated with bowel management.

## 2. Scope

This policy applies to all care staff including support workers and registered nurses involved in Complex Bowel Care for clients.

This document applies to: Registered and Endorsed Enrolled Nurses who are working within their scope of practice (Refer to Australian's health practitioner's regulation agency AHPRA)

The method of bowel care can vary greatly. This is determined by the treating doctor. It may include:

- Oral aperients
- Suppositories/ Enemas

## 3. Legislations and Standards

The National Disability Insurance Scheme (Quality Indicators) Guidelines 2018,

High Intensity Daily Personal Activities Module: Complex Bowel Care
Aged Care Quality Standards
*Aged Care Standards 3, 3 (a) I,ii,iii & 3, 3 (b).*
Australian Community Industrial Standards (ACIS) 2018, 5.4

## 4. Definitions

Constipation is a common gastrointestinal condition. It occurs when the colon is unable to remove waste through the rectum. People with this condition have three or fewer bowel movements over a seven-day period.

An enema administration is a technique used to stimulate stool evacuation. It is a liquid treatment most commonly used to relieve severe constipation. The process helps push waste out of the rectum when you cannot do so on your own.

Suppository is a solid dosage form that is inserted into the rectum where it dissolves or melts and exerts local or systemic effects. Suppositories are used to deliver medications that act both systemically and locally.

Spinal Cord Injury and Bowel Function The main changes to bowel function after spinal cord injury occur in the lower section of the digestive tract – the large intestine, rectum and anus.

Large Intestine is responsible for absorption of water from the faecal mass for use in all our bodily cells and functions. It propels the waste through the large intestine in wave like contractions of muscle towards the rectum for evacuation

Rectum holds the faecal bulk ready for evacuation




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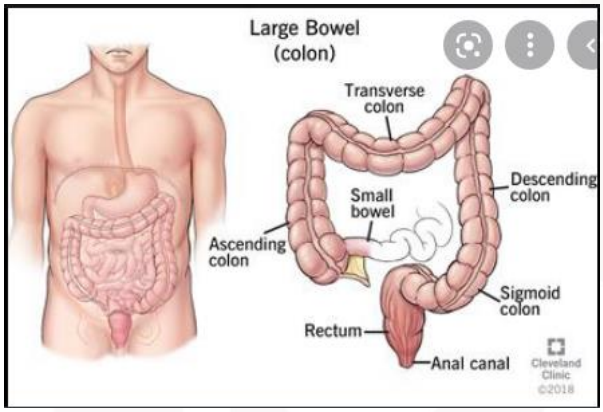
Anus controls the release of faeces during defaecation




## 5. Procedure

### 5..1 Assessment

The Registered Nurse completes an assessment of the clients support needs and with the client and or their advocate develops a Nursing Care Plan that reflects their individual needs and choice.

The main goals in bowel management include:

- Self-management of regular and predictable bowel emptying at a socially acceptable time and place

- Using a minimum of physical and pharmacological interventions to achieve complete bowel emptying within an acceptable timeframe

- The prevention of bowel accidents, constipation, autonomic dysreflexia and other complications

### 5.2 Panning

Nursing Care Plan reflects:

- Doctors' orders and recommendations
- Client input and choice into bowel care management plan
- Current best practice standards for bowel care management

An Action Plan that addresses how risks, incidents or escalation of incidents to emergencies in relation to bowel care for example overflows, bowels not open, signs of perforation, sinus, infection and dysreflexia are identified and managed.

The client and or their advocate has signed the Nursing Care Plan.

A copy of the Care Plan stays with the client and a copy is placed in the clients electronic file.

The care plan has a review date of 12 months but will be reviewed earlier if the client, support worker, or registered nurse identifies earlier review is needed.

Earlier review may occur due to change in client's needs, risks are identified, incident report that suggests a review of needs or emergency.

Support workers complete progress notes per visit.

Support staff will contact the service co-ordinator if the identify problems or risks whilst on shift with catheter management. This information is reported back to the Registered Nurse for review.

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An incident report is completed by the support staff if required. Service co-ordinator to follow up that the incident report is documented and followed up on by the registered nurse or Team Leader.

Nursing Care Plan is reviewed by the registered nurse with the client and or advocate if risks.

A bowel care plan has been developed and is overseen by a health practitioner with client input.

### 5.3 Process

Suppository/Enema

- Review Doctors order
- Explain procedure to client
- Ensure client has optimum privacy
- Gather equipment – suppository/enema, water-based lubrication, gloves, blue liner
- Position client on bed lying on left hand side and adjust bed to a comfortable height if able
- Put on gloves and remove suppository from casing or snap top off enema and apply lubrication
- Insert enema the full length of nozzle or insert suppository as high to rectum as possible
- For enemas, release contents and remove applicator
- Add – document type of movement as per Bristol stool chart.

Don't continue if too painful, document any bleeding, report if so.

## 6. Training and Competency

Subee Newlake's Clinical Governance Framework ensures all staff employed have the appropriate professional qualifications to carry out clinical support to clients with high intensity daily support activities.

The Registered Nurse/s of Subee Newlake are responsible for the training and competency checking of all support workers

Training is provided on a needs basis to support workers that are providing support to clients with complex bowel management.

Subee Newlake will support and train their support workers to:

- Complete competency training and assessment in the task
- Be aware of basic anatomy of the digestive system and importance of regular bowel care
- Understands autoniomic dysreflexia and symptoms of need for intervention
- Aware of the certain participants who are more at risk of severe constipation or faecal incontinence (about jT1) and ABI
- Knows related guidelines and procedures, nutrition and hydration requirements
- Follow personal hygiene and infection control procedures
- recognise the intensely personal nature of this type of support and make sure of the participant's consent for the approach
- observe and record change bowel habits
- Understands intervention options and techniques including administering enemas and supps, digital stimulation, massage etc




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- administer laxatives, enemas or suppositories according to procedure and identify when to seek health practitioner advice.
- Observe and record adverse signs post treatment/therapy
- Report any issues arising from the delivery of bowel care (such as: bowels not open, bleeding, constipation, diarrhoea) to the case co-ordinator for further advice
- Identify and report to their supervisor any gaps in their ability to deliver the required service

Class room and/or in-home bowel care management training with the registered nurse includes but is not limited to Peristeen, Enema Information, Constipation Information and Suppository information. This training is complimented with Support Workers completing the Altura eLearning Module Bowel Management.

Client Specific bowel care training is completed when required.

All training is recorded on TRACK competency training register with an annual review date

## 7. Risk Management

Along with staff competency/training specific to bowel care, training is provided in WHS, infection control and waste management.

A Bowel Care Action Plan has been developed for support workers to be able to respond to adverse effects and reactions of complex bowel care.

Bowel Care Action Plans are kept in Client folders with Client Support Plan and include procedure for incidents or emergencies related to constipation, dysreflexia, rectal bleeding, perforation and when to escalate to a health professional.

Thorough bowel chart and bowel medication documentation is required to manage bowel care.

All incident and reporting of side effects, adverse effects and injury will be recorded on TRACK. This is essential for risk management to clients and staff.

## 8. Related Forms and Supported Documentation

F-CH- 074 Bowel Management Chart
F-CH Bowel Movement Recording Chart
F – 102 Bowel Care Plan
F-CA – 89 Administering Bowel Medication

## 9. Related Policies & Procedures

Waste Management Policy & Procedure
Infection Control Policy & Procedure
Medication Policy and Procedure
Needle stick and Sharps Policy & Procedure
Clinical Governance Framework Policy and Procedure
Incident Reporting Policy
Confidentiality Policy

## 10. Resources

Guidelines for Levels of Attendant Care for People with Spinal Cord Injury, Lifetime Care Support Authority NSW 2007

NSW Health – Various documents www.health.nsw.gov.au then go to 'Publications and Resources' 'Policy Directives and Guidelines' then either "search by A to Z" or search specific word/s eg. Bowel care




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Management of the Neurogenic Bowel for Adults with Spinal Cord Injuries- ACI NSW Agency for Clinical Innovation
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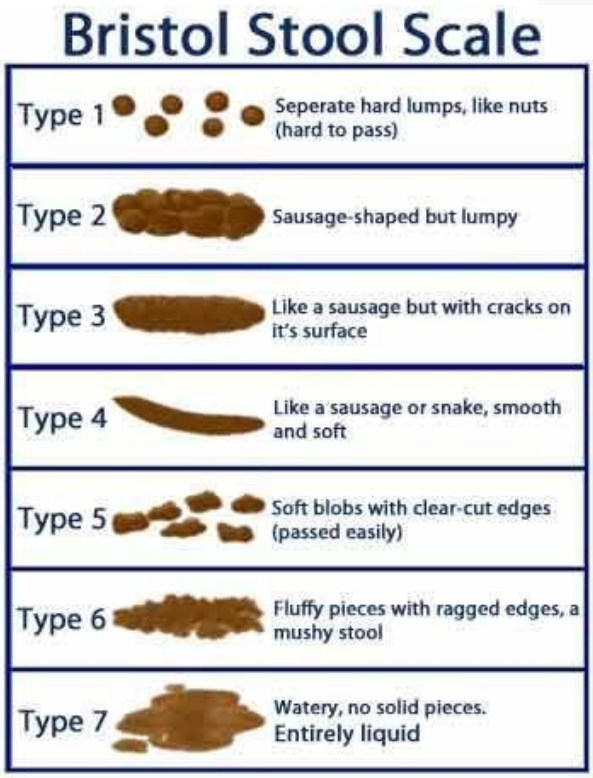





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