Bowel management workbook
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Training and assessment information

Welcome
Welcome to your course and Premium Health. The aim of this resource is to provide the essential knowledge and skills you require to effectively support residents in normalising their bowel function and with elimination through the administration of suppositories and enemas.

Helping you to succeed in your course
We believe learning should be an enjoyable and challenging process and we understand that each learner is different. A variety of methods such as class participation, group discussion, scenarios, workbook exercises and opportunities for practice will help you to achieve competency.

We select our Premium Health trainers and assessors carefully. All are nurses or paramedics with appropriate qualifications, technical expertise and experience in both education and emergency first aid and in the disability or health care sector. This enables them to provide you with quality training which is grounded in experience and knowledge of the field.

Performance outcomes
On completion of this course you will be able to:
- Identify what is normal bowel function
- Identify the anatomy and physiology of the lower intestine
- Identify the major causes, signs and symptoms of constipation
- Define strategies used to maintain regular bowel function
- Explain bowel training goals and process
- Competent demonstration of the safe administration of suppositories and enemas (Microlax)

Statement of Participation
A Statement of Participation will be issued upon successful achievement of the assessment tasks in this non-accredited course.

Evaluation of the course
A student feedback form is provided at the back of the workbook. Your feedback is important to us as we use this as part of our continuous improvement cycle. Please complete the form at the end of your course.

Premium Health’s customer service
We offer you an on-going service in relation to course information and invite you to call our office on 1300 72 12 92 or email us on info@premiumhealth.com.au.

For more information about Premium Health specialised health and first aid courses, products, services and policies, access our website www.premiumhealth.com.au
Bowel management

Many residents who require monitoring and extra support with faecal evacuation usually are affected by chronic constipation. As support staff, understanding the factors which contribute to bowel problems makes it easier to routinely implement management strategies to minimise the effects of or reduce the likelihood of chronic constipation for residents. Often, simple measures can be put in place to minimise or prevent the development of constipation. These include simple lifestyle measures such as adequate daily fluid intake, regular exercise and a varied diet, high in fibre plus a regular toileting program, including not ignoring the urge to open the bowels, particularly just after rising or after a meal.

Bowel function

The bowel is one of four main elimination systems of the body (skin, lungs, bladder, and bowel). It is made up of sections with a total length of approximately 140-170cm.

Absorption and storing faecal material are the colon’s two main functions. The colon does secrete mucous to help the digested food along and hold the faecal material together. It also plays a role in protecting the walls of the colon from bacterial activity and neutralises some of the faecal acids.

After processed matter from the small intestine enters the colon most absorption occurs in the ascending colon. Mixing movements occur every few minutes and last about one minute each time. The roll and mix of the matter exposes most of it to the colon’s surface for absorption. As food moves through the colon, the colon absorbs water from the food while it forms waste products, or stool. Muscle contractions in the colon then push the stool toward the rectum. By the time stool reaches the rectum it is solid, because most of the water has been absorbed. Over 80% of the material reaching the colon is reabsorbed.

Emptying the bowel is called defaecation. Defaecation involves the co-ordination of pelvic floor and abdominal muscles, colonic (bowel) activity, comfort and positioning. Once the stool moves into the rectum, a nerve reflex is set up and the brain gets the signal that it is time to defaecate. The external sphincter is under voluntary control and we can mentally overcome this reflex and prevent defaecation if we want to. Delays can result in constipation and other bowel problems.

The bowel should evacuate easily, that is without straining. The stool should be soft and easy to pass. Normal bowel habits vary considerably from person to person. Anything from several times a day to several times a week can be quite normal. It is the consistency of the stools rather than the frequency that is more important.

If someone is having difficulty emptying their bowel it may be due to one of the following:

- Constipation
- No “message to go” – not feeling the urge to go because of a problem with the nerves in the anal sphincter
- A problem with the muscles in the pelvic floor or anal sphincter

Sometimes these problems are made worse by repeated straining, weakness in the pelvic floor muscles or an inability to release the anal sphincter.

A measure of bowel function is transit time. Transit time refers to the time it takes for food to travel from the mouth to the anus and can be anywhere between 18 to 72 hours. Around 48 hours is considered normal and over 72 hours is slow. Bowel transit times can be affected by certain medicines, illness or dehydration.
Constipation

Constipation is a condition that affects many people around the world. It is described as having a bowel movement fewer than three times per week and difficulty in defaecation (emptying the bowel) over an extended period of time. It also is characterised by the type of faeces (stool or poo) which is passed.

The frequency of normal bowel actions ranges between being opened three times a week to three times a day. As can be seen from this range, everyone has different bowel habits. A commonly used method of classifying the faeces a person passes is The Bristol Stool Chart which is a scale or medical aid. It is a good representation of the amount of time the faeces has remained in the bowel. It can therefore assist in recognising if the person requires intervention to normalise their bowel function.

Types 1 -2 are the types of stools which are passed by someone who is constipated. Types 3 and 4 are classified as normal faeces and Types 5, 6 and 7 are those which are passed when someone either has loose bowel actions or diarrhoea.

Constipation is a symptom, not a disease. Almost everyone experiences constipation at some point in their life, and a poor diet typically is the cause. Most constipation is temporary and not serious. Understanding its causes, prevention, and treatment will help most people find relief and help to prevent constipation from recurring.

**Bristol Stool Chart**

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces. Entirely Liquid</td>
</tr>
</tbody>
</table>

The Bristol Stool Chart was devised by gastroenterologists from the University of Bristol in the UK. Reference: Lewis SJ, Heaton KW (1997). "Stool form scale as a useful guide to intestinal transit time". *Scand. J. Gastroenterol.* 32 (9): 920–4

**Signs and symptoms of constipation**

The following are signs and symptoms of constipation
- Hardened, dry stools
- More than 3 days between bowel movements
- Pain during elimination
- Straining
- Feeling of incomplete evacuation
- Feeling bloated, uncomfortable and sluggish
- Behavioural changes
Loose stools with impacted faeces

Signs and symptoms of constipation in children

The signs of constipation in children include the child complaining that it hurts doing a “poo” complaining of pains in their tummy and showing signs of holding on such as crying and refusing to sit on the toilet, crossing legs, squatting, running around. In severe cases of constipation the child may complain of feeling hungry, eat and then vomit. This situation requires medical intervention.

What causes constipation?

Constipation occurs when the colon absorbs too much water or if the colon’s muscle contractions (gastric motility) are slow or sluggish, causing the stool to move through the colon too slowly. Due to this stools become hard and dry. Decreased gastric motility slows the passage of faeces through the large intestine resulting in increased fluid absorption from the faecal mass.

Common causes of constipation include diet, pain, dehydration, immobility, certain groups of drugs and pregnancy. More specific causes of constipation are such things as stroke, neurological disorders such as Parkinson’s disease, and spinal cord injury.

The risk factors for constipation mainly stem from fluid intake, diet, mobility, and the person’s environment. There is also a link between ageing and the increased likelihood of constipation.

Low fluid intake is considered a risk factor as it is linked to slow colonic transit which slows passage of food through the large bowel resulting in a low stool output. Dietary fibre has been clearly shown through studies to increase bowel transit time and improve how often the bowels open. Disease of the digestive system is very common in Western societies as a contemporary diet often has little fibre or roughage.

Lack of mobility or little exercise has been shown to increase constipation. Environmental issues like lack of privacy, difficult access to toilets or having to rely on other people for assistance with toileting contributes to constipation because the person may have to ‘hold on’. Other factors like depression or anxiety, impaired cognitive function e.g. dementia and some medications may also increase the risk of constipation.

Causes of constipation in children

Constipation is also common in children. The factors for constipation in children reflect the causes in the general population.

They include: if a child drinks too much milk and not eating enough solids (lack of dietary fibre); ignoring the urge to go to the toilet (holding on); holding back because they are being toilet trained; not getting enough exercise, not drinking enough water. Some children don’t like to use pre-school or school toilets because of lack of privacy or if they think that the toilets are “smelly”.

Children also may develop anal fissures which are small splits of the skin in the anus or bottom. These fissures cause pain and bleeding when a child attempts to open their bowels. This can set up a vicious cycle with the child not wanting to open their bowels and holding on which makes their constipation worse. Some children are afraid of the toilet and are worried that they might fall in or get “flushed” away!

It is important to look at ways that these frightening situations can reduced or eliminated.

Constipation and bladder control

It is important to be aware that constipation can affect urinary incontinence. An over-full bowel can press on the bladder, reducing its capacity and causing toilet urgency, frequency and bladder leakage. This is sometimes called an overactive bladder and is a risk factor for urinary tract infections (UTI’s).
Autonomic dysreflexia

Autonomic dysreflexia is a medical emergency that can occur in people with a spinal cord injury (at or above the T6 level). It occurs when a sensation below the level of the spinal cord lesion, that would normally be painful, causes excessive reflex activity in the autonomic nervous system (part of the peripheral nervous system (PNS)). What occurs is a sudden and severe rise in blood pressure that can result in:

- Brain haemorrhage
- Seizures/Fits
- Arrhythmias
- Heart palpitations
- Possibly death.

Other signs and symptoms include:

- Sudden rise in blood pressure
- Severe pounding headache
- Bradycardia (very slow pulse)
- Flushing/blotching of skin on the head and neck
- Sweating (profuse) above the area of the SCI lesion level
- Goose bumps and skin pallor below the area of the SCI lesion level
- Chills without fever
- Nasal stuffiness
- Blurred vision
- Shortness of breath and anxiety.

Common causes:

- Bladder-related: bladder distension, blocked catheter, UTI
- Bowel-related: constipation, inflamed haemorrhoids
- Skin-related: pressure sores, burns, ingrown toenails, tight clothing
- Other: Fractures, kidney stones, labour, menstrual cramps, distended stomach.

Preventing constipation

Prevention is best practice. All the identified risk factors should be addressed wherever possible. Diet, fluid intake and exercise can be modified to reduce or eliminate constipation.

There are ranges of ways to manage constipation from non-pharmacological measures, non-laxative interventions and medications which have different actions on the bowel or bowel contents.

Regular daily exercise, drinking plenty of water and eating plenty of high fibre foods will help in maintaining a healthy bowel. Fibre from plant foods increases the bulk and softness of stools, making them easier to pass. A diet with enough fibre helps the body form soft, bulky stool.

High fibre foods include fresh fruits and vegetables and other foods such as: apricots, prunes, figs, alfalfa sprouts, almonds, apple, banana, beetroot, carrot, cauliflower, honey, peach, pear, pine nuts, seaweed, sesame seed/oil, spinach, walnuts, beans, whole unprocessed goat's milk, legumes and whole grains. Paradoxically, too much fibre can cause constipation as it draws water from the bowel.

Another intervention that may help in preventing constipation is drinking adequate water and being well hydrated. It is recommended that adults drink 6-8 glasses of water per day.

Going to the toilet when the urge is felt and allowing enough time to have a bowel movement is important. Generally it should take only a minute or so to empty your bowel. Opening the bowels when there is a strong urge to go usually occurs soon after meals. Ignoring the urge to open the bowels is a poor habit. People who ignore the urge may eventually stop feeling the urge, which can lead to constipation and incontinence. Advise residents not to strain or hold their breath when going to the toilet. Haemorrhoids (or piles) can result from straining.
Good toilet positioning assists in straightening out the angle between the rectum and anus, which makes it easier for faeces to be passed. Advise your resident to lean forward while sitting on the toilet, with a straight back with the forearms or elbows resting on the thighs. The feet should be raised so that the legs are angled slightly upward and away from the body. A footstool may help in finding the best angle. This position is not recommended for people who have had a hip replacement as it may affect or dislocate the hip prosthesis.

It may take a while for people to get used to this position. Some cultures achieve this position automatically when squatting or using squat toilets.

Managing constipation

People with a history of chronic constipation, impaction and incontinence may benefit from a bowel training program. The purpose is to manipulate factors within our control such as food and fluid intake, exercise and toileting times, and to produce the elimination of a soft, formed stool at regular intervals without laxative support.

Bowel training re-establishes the bowel's normal reflexes by repeating a routine until it becomes a habit. Naturally the resident must be able and willing to cooperate. Some patients are so convinced they need daily laxatives that they are afraid to do without them. It takes time for a changed diet to affect the bowels and for the bowel to regain its normal rhythm. Trust and patience are necessary.

Bowel training often involves creating a schedule for trying to have a bowel movement. For instance, some people with a weakened anal sphincter (the muscle around the anus) or those with certain nerve problems may not recognise the sensation that their rectum is filling and they need to have a bowel movement. Bowel training in this situation involves sitting down on the toilet, even if there is no urge to go.

People with constipation can train their bodies to get things moving by taking certain steps after eating. The colon tends to be most active after a meal. This is because of the gastrocolic reflex, which senses food in the stomach and sends the lower gastrointestinal tract the message that it is time to defaecate. If constipated, sitting on the toilet for 20 to 30 minutes following a meal; even if no urge to have a bowel movement; can encourage the bowels to move.

If suppository use is required:

- 30 minutes before a resident’s usual toileting time administer a suppository to stimulate peristalsis
- When the resident has the urge to evacuate assist resident to the toilet, allow privacy and adequate time, avoid rushing or abandoning the resident
- Offer positive reinforcement and encouragement
- This routine should be followed daily, then every other day, and then every third day
- The idea is to gradually eliminate the need for suppositories
- If the above program is followed strictly, the bowel should be trained to empty at the same time every day

http://www.thewomens.org.au/NormalBowelFunction
- Some people follow this same routine but use an enema instead of suppositories as a means of training the bowel for timed evacuation.

A bowel training program:
- Explain to the resident the purpose of the program
- Assess the resident's elimination patterns and toileting times over a 14 day period
- Increase fibre in the diet
- Increase exercise
- Design a plan to modify lifestyle variables
  - Increase fluids to 2500-3000ml per day
  - Include hot drinks and fruit juices

A bowel training program provides the resident with an established and regular pattern. Continue to offer assistance with toileting at the successful time and discontinue the use of a suppository.

When to contact a doctor
If at any time, any of the following occur a doctor should be consulted:
- Severe abdominal pain
- Pain or vomiting along with constipation
- Sudden weight loss
- Constipation > 7 days
- Constipation alternates with diarrhoea
- Bowel motions are very dark or tarry looking
- Severe straining with no movement being passed
- Normal routine was one bowel movement per day and has now been more than 3 days
- Blood around the stool or problems with haemorrhoids
- Resident has significant decrease in bowel movements

Oral laxatives
Most people who are mildly constipated do not need laxatives. However, for those who have made diet and lifestyle changes and are still constipated, a doctor may recommend aperients or laxative therapies for a limited time where there is short-term or identified chronic problem with bowel function. Laxative therapies are used in conjunction with the lifestyle measures. These treatments can help retrain a chronically sluggish bowel.

Generally the therapies are used in a sequenced approach with the first step being the use of bulking agents, followed by lubricants or faecal softeners, irritant or peristaltic stimulants with osmotic laxatives being used as a last measure. The use of enemas and suppositories may be recommended by the doctor, but usually only when all other methods have shown not to be effective.

Laxatives affect the bowel through use of bulking agents, lubricant laxatives, irritant or peristaltic stimulants and osmotic laxatives. It is important to consult your doctor or continence advisor regarding which type of laxative is best suited to your resident's needs.

Bulk forming agents
Bulk forming laxatives are very good as first line agents for constipation. Bulking agents are generally considered the safest, but they can interfere with absorption of some medicines. These agents increase the bulk of the stool by absorbing water in the intestine making the stool softer and stimulate peristaltic activity. An adequate fluid intake is essential with these laxatives. Where there is an inadequate fluid intake, especially in the elderly, they should be used with caution. They must not be used if there is bowel obstruction or if faecal matter is impacted. Results can take up to 48-72 hours. These laxatives always should be taken with water. They mainly work on the large bowel or colon.

Bulk forming laxatives with bowel stimulants should generally be used only in the short-term and then changed to a standard bulk forming laxative as advised by a doctor.
Some brands of bulking agents are:
- Normafibre
- Benefibre
- Normacol Plus
- Nulax
- Metamucil

**Faecal softeners / lubricant laxatives**

These work by softening or greasing the faeces. Faecal softeners such as docusate sodium (Coloxyl) help water penetrate into the faeces, making them softer and easier to pass. Faecal softeners are very good for treating constipation, particularly if required long-term or if the person has haemorrhoids. This enables the stool to move through the intestine more easily.

Softeners typically result in a bowel movement within 24-72 hours. The lubricant laxative acts on the small and large intestine (bowel). Some well-known brands are:
- Docusate such as Coloxyl or Coloxyl oral drops
- Liquid paraffin such as Parachoc for children and Agarol

**Osmotic laxatives**

These retain fluid in the colon by osmotic effects and stimulate the peristaltic action of the colon. The results may take up to 24-72 hours. Some brands of oral osmotic laxatives include:
- Movicol
- Sorbitol e.g. Sorbilax
- Lactulose e.g. Duphalac
Irritant or peristaltic stimulant laxatives
These promote bowel movement by irritating or stimulating the nerve endings in the bowel wall. They cause rhythmic muscle contractions in the large intestine or colon. Stimulant laxatives such as bisacodyl (Durolax) and senna (Senokot, Coloxyl with Senna and Sennesoft) may be required when constipation is severe and a rapid effect is required. They should not be used regularly unless under medical supervision.

The onset of action is about 8-12 hours. After complete evacuation of the bowel by a stimulant laxative, it may take 2 to 3 days for faecal matter to collect in the bowel again, and so taking a stimulant laxative every night is not usually necessary.

Stimulant laxatives should not be used during pregnancy. Some brands of irritant agents are:
- Senna e.g. Senokot and also Coloxyl with Senna
- Biscodyl e.g. Dulcolax

Enemas and suppositories
Enemas and suppositories may be prescribed to treat constipation or other medical conditions. These work by stimulating the rectum to empty. The basic principle is the solution is passed into the bowels and causes a shift in the concentration levels of the intestine, due to which the process of osmosis starts. This process helps to pull out all the toxins and excrement from the body. It also causes an increase in the water levels of the excrement, thus helping in giving a proper colon cleanse and making the stools relatively softer, and the process of defecation a lot less painful.

Some enema and suppositories:
- Microlax enema is common as a laxative which softens the stool
- Dulcolax suppository is common in treatment of constipation as it stimulates the bowel muscles within the rectum to promote peristalsis
- Glycerine suppository lubricates the rectum and anus
- Fleet enema is a saline laxative enema. It works by pulling water from the body into the bowel, which helps to soften the stool and cause a bowel movement.
- Rectal Valium is prescribed for seizure management

An enema should **not** be given if
- The resident is allergic to any of the ingredients listed
- Out of date
- Packaging is torn
- Treating any other complaint unless prescribed by Doctor

Suppositories should not be given
- Immediately post abdominal surgery i.e.: appendicitis
- If there is a condition in the intestine called ‘ileus’
- If there is an intestinal obstruction
- If there is inflammatory bowel disease
- If the resident is severely dehydrated

Any of the above conditions will mean that the person is under close medical supervision or in hospital.

Contraindications to suppository and enema delivery include recent colorectal surgery, an abnormal growth in the perianal region, mass, faecal impaction/obstruction, bleeding and pain.

**Microlax enema**  **Dulcolax suppositories**  **Glycerin suppositories**  **Fleet enema**

**Administering an enema or suppository**

When administering an enema or suppository you need to prepare the resident. Explain the procedure to the resident and the effect of the suppository or enema. You will need to allow the resident to urinate if needed. Check resident notes for previous abnormalities or rectal surgeries and check prescription/drug chart. Enemas and suppositories must be at room temperature. This will minimise shock and prevent bowel spasms.

Collect all the equipment required.
- Tray/trolley
- Prescribed enema or suppository
- Lubricant (water based)
- Gauze swabs
- Disposable gloves (powder free non-sterile latex)
- Disposable apron
- Waste bag
- Incontinence pad or a bluey or kylie

**Procedure for administration of enema or suppository**

1. Ensure that the bed is protected
2. Wash hands, put on apron and gloves
3. Ensure the residents privacy and that they have immediate access to the toilet
4. Position resident on their LEFT side in lateral position with their knees up towards their chest
   - This will aid relaxation and minimise resistance and discomfort on insertion
The descending colon and rectum are positioned on the left side of the body
5. Ask the resident to breathe deeply
6. Ensure enema or suppository is entirely lubricated before insertion using water based lubricant and gauze swab
7. Separate the resident’s buttocks lubricate the anal area with water based lubricant and gently push into the rectum
8. Resident should be encouraged to remain lying for at least 15-20 minutes (or as per instructions)
9. Gloves, bluey, packaging and other waste is disposed of appropriately
10. Assist resident to toilet when needed
11. Wash hands following procedure
12. Document all enemas or suppositories given in case notes, refer to bowel charts for effectiveness

Procedure
An enema insertion for an adult is the length of the insertion tube and for a child it is ½ length of insertion tube. A suppository insertion for an adult is 4cm into the rectum and for a child 2cm into the rectum.

Where there is a faecal mass, suppositories or enemas are not to be inserted into the faecal mass, they should be inserted between the faecal mass and mucous membrane wall of the rectum. Encourage resident to walk about if ambulant as this often helps promote peristalsis.

**Warning:** When giving a suppository to a resident, the person administering the suppository must have fingernails that are natural and short – no longer than the end of the fingertips. Suppositories should not be administered by anyone with long or artificial fingernails. There is a risk of damage to the bowel, including rupture.

Summary
Support, encouragement and the implementation of preventative measures can assist you and your resident with healthy regular elimination.
Bibliography and resources

Victorian Continence Foundation and Victorian Continence Resource Centre
RDNS Building Royal Talbot Rehabilitation Centre
Yarra Boulevard Kew Vic 3101
Phone: (03) 9816 8266 Fax: (03) 9853 9727
www.continencevictoria.org.au
http://d1526731.i86.quadrahosting.com.au/node/10

Department of Health of Health and Ageing
Bladder and Bowel website

Department of Health, Victoria
Home Page: Keyword search: Bowel / constipation; Publications,
www.health.vic.gov.au

Department of Human Services, Victoria
Home Page: Keyword search: Constipation

Better Health Channel, Victoria
Home Page: A-Z of Conditions: Constipation Fact Sheets, Conditions and Treatments, Healthy Living

The Joanna Briggs Institute, Faculty of Health Sciences,
The University of Adelaide, South Australia, 5005, Australia
Best Practice Management of constipation in older adults

Royal Children’s Hospital, Melbourne
Fact sheet: Constipation in children
http://www.rch.org.au

Health InSite Health Direct Australia

Department of Education and Early Childhood Development
Home Page keyword search: Constipation

National Digestive Diseases Information Clearinghouse
U.S. Department of health and Human Services
http://digestive.niddk.nih.gov/ddiseases/pubs/constipation/

International Foundation for Functional Gastrointestinal Disorders
http://www.aboutconstipation.org/site/about-constipation/treatment