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HEALTH CARE

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Bowel Management - Elimination

PREMIUMHealth

In the spirit of reconciliation Premium Health acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respects to their elders past, present and emerging and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

OUR PROMISE

Premium Quality, without compromise. It's the Premium Health promise.

Phillipa Wilson
Founder & Managing Director of Premium Health

Our Trainers are Experienced Nurses and Paramedics	Passionate about sharing their experience
Premium Quality Programs	We pride ourselves on the depth of our course content and the quality of our training materials
Innovative Techniques, Empowering Outcomes	Methods remembered for years to come
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Welcome to your course and Premium Health.

The aim of this resource is to provide the essential knowledge and skills required in your training.

We select our Premium Health trainers and assessors carefully. All are either nurses or paramedics with appropriate training qualifications, technical expertise and experience.

BOWEL MANAGEMENT – ELIMINATION

WHAT YOU NEED TO KNOW ABOUT YOUR COURSE

Welcome

The aim of this resource is to provide the essential knowledge and skills required to effectively support clients in normalising their bowel function and elimination through the administration of suppositories and enemas.

Evaluation of the program

Your feedback is important to us as we use this as part of our continuous improvement cycle. Please undertake the evaluation which will be discussed by your trainer during the course.

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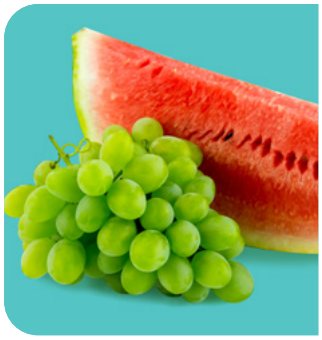
BOWEL MANAGEMENT

Many clients 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 clients.

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 that is high in fibre. A regular toileting program should be introduced with emphasis on paying attention to "feelings and urges" to open the bowels particularly just after rising or after a meal.

Exercise

Varied Diet



Adequate daily intake

Regular toileting program

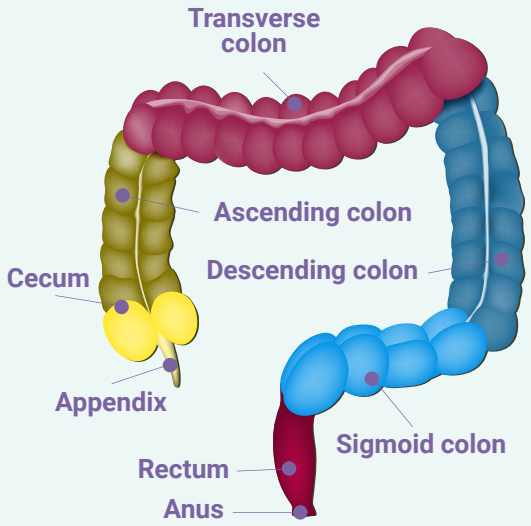
A client's health care plan should detail any relevant conditions and factors that contribute to a client needing support with their bowel function.

The plan should include any lifestyle factors and/or medical interventions such as medications to be utilised to assist effective bowel elimination. The plan will determine what monitoring and recording requirements are needed for the client in addition to any signs and symptoms that require a client to be reviewed earlier than next scheduled review date.

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.

Anatomy of the Large Intestine

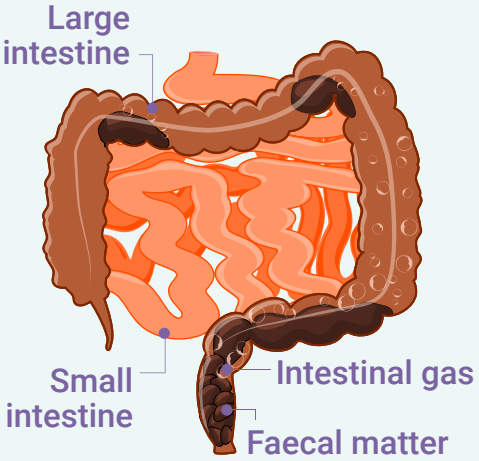


Absorption and storing faecal material are the colon's two main functions. The colon does secrete mucous to help the digested food along and hold the faecal material together. It also plays a role in protecting the walls of the colon from bacterial activity and neutralises some of the faecal acids.

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 expose 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 (called peristalsis) 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, 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.



A healthy bowel is more than just passing soft form stools at regular intervals. It also means a person can:

- hold on to a bowel motion for a short time after feeling the urge to defecate
- being able to initiate defecation within approximately a minute of sitting on the toilet
- complete evacuation of faecal matter from bowel when evacuating

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 medications, 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 have remained in the bowel. It can therefore assist in recognising if the person requires intervention to normalise their bowel function.

Types 1 and 2 are the types of stools which are passed by someone who is constipated.

Types 3 and 4 are classified as normal faeces.

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.

Constipation

TYPE 1

Separate hard lumps, like nuts

TYPE 2

Lumpy and sausage-like

Perfection

TYPE 3

Sausage share with cracks

TYPE 4

Like a smooth soft sausage or snake

Inflammation

TYPE 5

Soft blobs with clear-cut edges

TYPE 6

Mushy consistency with ragged edges

TYPE 7

Liquid consistency with no solid pieces

SIGNS AND SYMPTOMS OF CONSTIPATION

The following are signs and symptoms of constipation:

- hardened, lumpy, dry stools
- more than 3 days between bowel movements
- pain during elimination
- straining
- feeling of incomplete evacuation
- feeling bloated, cramping or uncomfortable and sluggish
- feeling nauseous, decrease or loss of appetite
- behavioural changes
- loose stools with impacted faeces
- bleeding from rectum after passing faeces

SIGNS AND SYMPTOMS OF CONSTIPATION IN PEOPLE WITH AN INTELLECTUAL DISABILITY

The signs of constipation in people with an intellectual disability include:

- the person complaining that it hurts doing a “poo”
- complaining of pains in their tummy
- showing signs of holding on such as crying and refusing to sit on the toilet, crossing legs, squatting, running around
- severe cases; complaining of feeling hungry, eating and then vomiting. This situation requires medical intervention
- abnormal behavioural patterns like irritability, aggression, temper tantrums, disrupted sleep patterns, straining and withholding behaviour

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.

Lifestyle factors that are a common contributing factor to constipation include:

- poor diet; low fibre diet
- poor water intake
- lack of exercise or activity; sedentary lifestyle or restricted movement due to disability
- pregnancy; hormone changes, reduced activity, and pressure against the large intestines
- change in routine
- habit to delay going to the toilet
- medications including narcotics for example codeine, antidepressants, iron supplements, medications used for hypertension known as calcium channel blockers and non-magnesium antacids
- illness: a mixture of the above factors, are often associated with hospital stays or convalescing from illnesses

Medical related factors that contribute to constipation include:

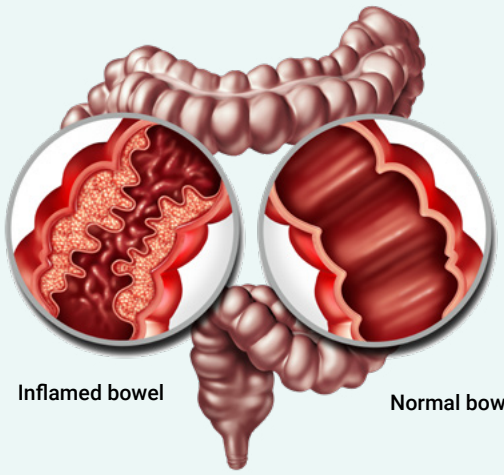
- slow transit time: some people naturally have a slow transit time of faeces through the bowel and any changes to routine quickly lead to constipation
- central nervous system diseases; Multiple Sclerosis, Stroke and Parkinson’s disease
- spinal cord or brain injuries
- tumours, anorectal blockage, and intestinal obstructions
- endocrine diseases; diabetes, hypothyroidism, and hypopituitarism
- inflammation: resultant or linked to diverticular disease, Crohn’s disease, and Ulcerative Colitis
- coeliac disease
- irritable bowel disease

The risk factors for constipation mainly stem from inadequate fluid intake, inadequate diet, poor mobility, and the person's overall 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.



Crohn's disease is a type of inflammatory bowel disease most commonly affecting the small and large intestine but can affect any part of the gastrointestinal system. People suffering Crohn's often avoid high-fibre food, as they can often irritate their stomachs, can be dehydrated due to bouts of diarrhea and typically are taking a combination of medications, all of which can cause constipation. One of the severe complications of Crohn's is a narrowing of a section of the intestine from scarring known as a stricture. The stricture can lead to blockages or obstructions of faecal matter in the intestines, and constipation is an early symptom of a stricture development.

Ulcerative Colitis is an inflammatory disease of the bowel that causes inflammation along the lining of the large intestine and rectum. When this inflammation occurs in the rectum, it causes spasms, and the pelvic floor does not relax, this is known as proctitis, and the condition makes it difficult to defecate (poo).

Coeliac disease is a disorder where a person's immune system will trigger an inappropriate response to the presence of gluten. The response causes inflammation which damages the small intestine. The damage to the small intestine can lead to excess fluid being absorbed from the faeces, as nutrients are failed to be absorbed. The hardened stools are then difficult to pass.

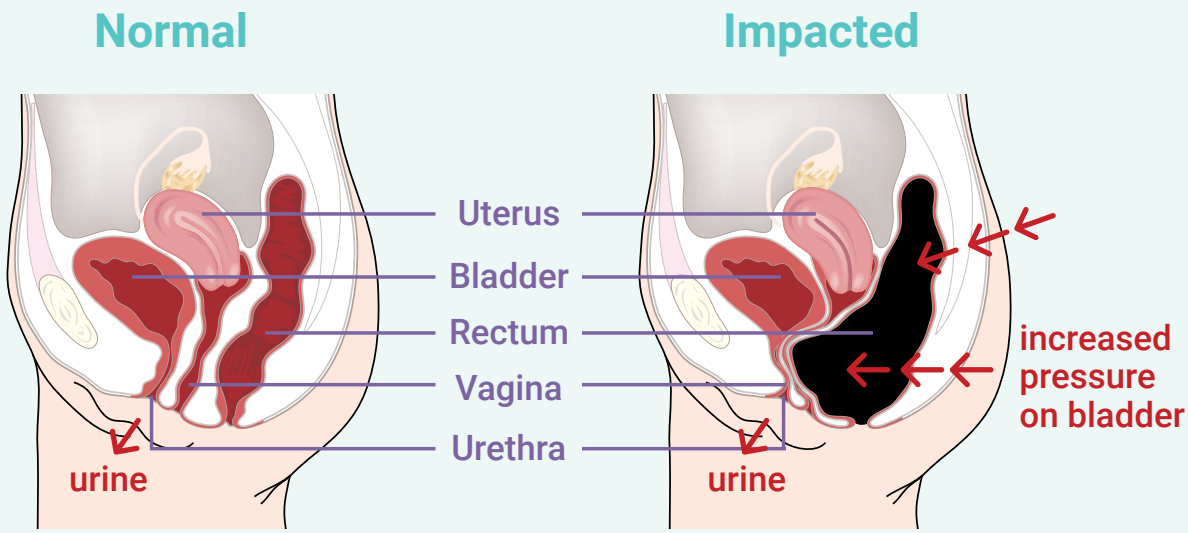
CAUSES OF CONSTIPATION IN CHILDREN AND PEOPLE WITH AN INTELLECTUAL DISABILITY

Constipation is also common in the above two groups. The factors for constipation reflect the causes in the general population. They include:

- drinking 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
- lack of privacy going to the toilet; some people do not like to use toilets outside their home environment

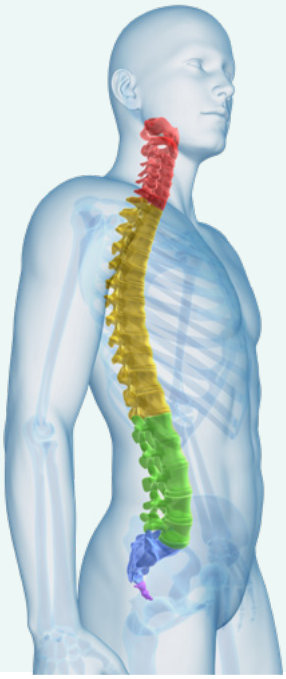
This group may develop anal fissures which are small splits of the skin in the anus or bottom. These fissures cause pain and bleeding when a person attempts to open their bowels. This can set up a vicious cycle with the person not wanting to open their bowels and holding on which makes their constipation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

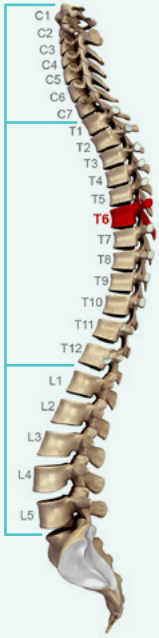
It is important to look at ways that these frightening situations can reduced or eliminated.



CONSTIPATION AND BLADDER CONTROL

It is important to be aware that constipation can affect urinary continence. 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).





Acknowledgement: Continence Foundation of Australia 2020, Continence and Bowel Control

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:

- severe pounding headache
- bradycardia (very slow pulse)
- flushing/blotching of skin on the head and neck
- sweating (profuse) above the area of the spinal cord injury level
- goose bumps and skin pallor below the area of the spinal cord injury level
- chills without fever
- nasal stuffiness
- blurred vision
- shortness of breath and anxiety

Common causes:

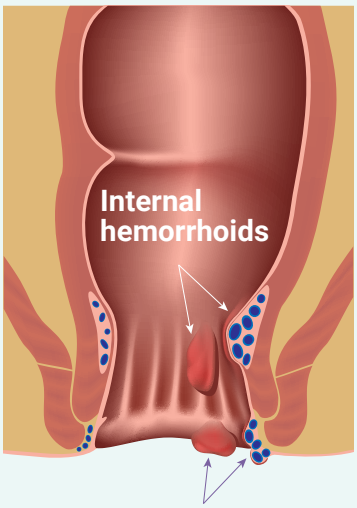
- bladder-related: bladder distension, blocked catheter, UTI
- bowel-related: constipation, inflamed haemorrhoids
- skin-related: pressure sores, burns, ingrown toenails, tight clothing
- other: fractures, kidney stones, labour, menstrual cramps, distended stomach

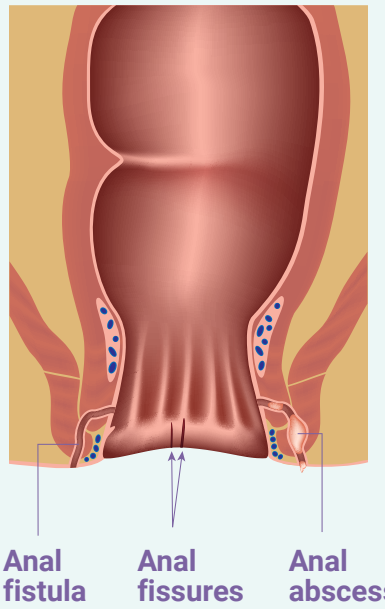
Long term complications of chronic constipation include:

- rectal prolapse
- haemorrhoids
- anal fissure
- diverticular disease
- faecal impaction

Straining whilst trying to evacuate faecal matter, can result in the veins in the anus and around the lower rectum to swell. This is known as haemorrhoids or piles. Haemorrhoids can cause further discomfort and pain during bowel elimination, bleeding during evacuation of faecal matter, swelling, irritation and itching around the anus.

Anal Disorders





HAEMORRHOIDS

Haemorrhoids, also called piles, are swollen veins in the lower rectum and anus, similar to varicose veins. They are generally painless, but can bleed and may cause pain.

Signs or symptoms of haemorrhoids include:

- extreme itching around the anus
- irritation and pain around the anus
- itchy or painful lump or swelling near the anus
- faecal leakage
- painful bowel movements
- blood on toilet tissue after having a bowel movement

Although haemorrhoids are painful, they aren't life threatening and often go away on their own without treatment, however some intervention may be needed.

Haemorrhoids medical intervention can be:

- over the counter haemorrhoid creams or ointments
- haemorrhoid suppositories
- oral analgesia for pain and discomfort

RECTAL PROLAPSE

Constant straining over time, due to difficulty in bowel elimination can lead to rectal prolapse. This is where part of the large intestine, the rectum, comes away from its normal position and can slip out of the anus.

Signs or symptoms that may indicate a client has a rectal prolapse;

- itching, irritation and/or pain around the anus
- a feeling of incomplete evacuation
- leakage of blood, mucous or faeces from the anus
- red tissue (intestine) protruding from the anus

In most cases of rectal prolapse, surgery is required to place the large intestine back into correct positioning. However, if the rectal prolapse is in its early and minor forms a healthcare physician may implement dietary changes, Kegel exercises and other home treatments.

ANAL FISSURE

A small tear in the anal tissue is known as an anal fissure, which can make further bowel motions very painful.

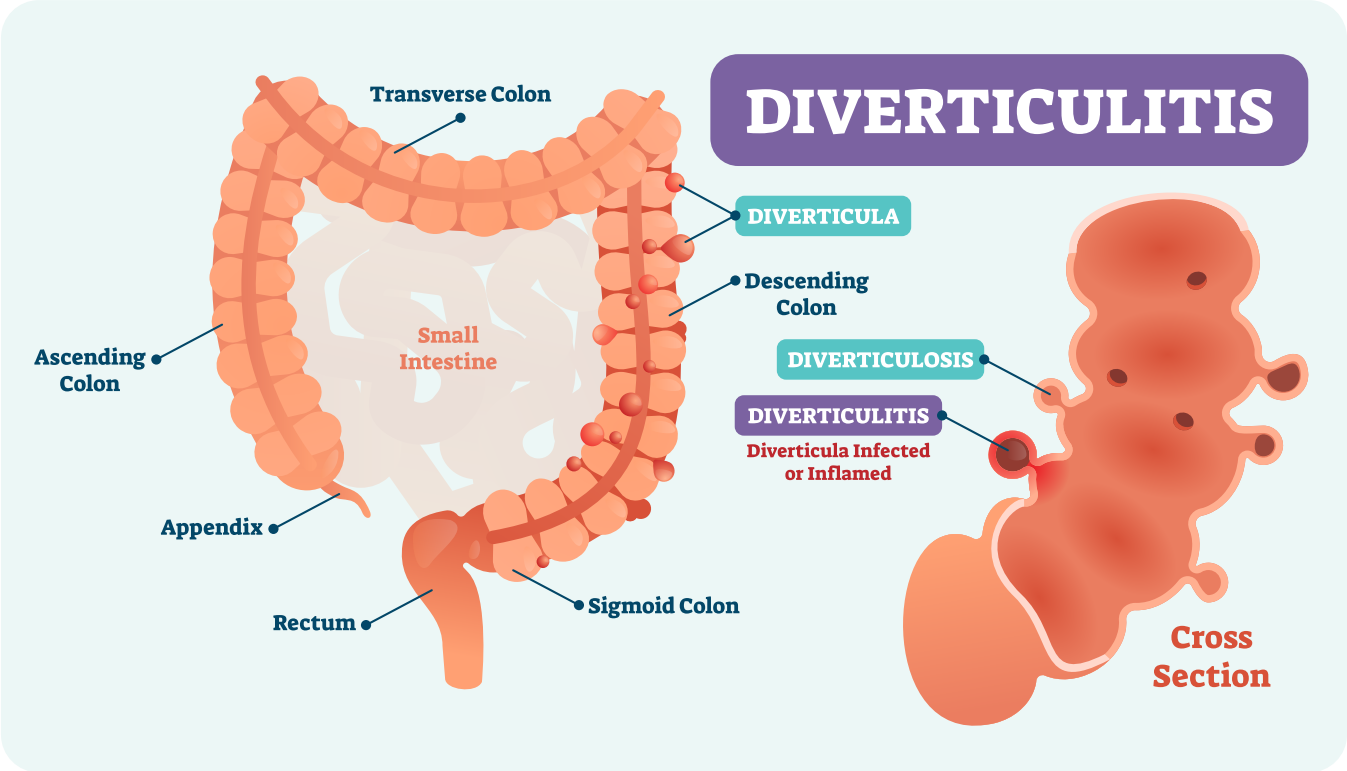
Signs and symptoms of an anal fissure include.

- oral medicated treatment
- a visible tear around the anus
- pain during or post bowel elimination
- bright red blood on the toilet paper or around the faecal matter
- a skin tag or bum near the tear

Anal fissures can require the following medical interventions:

- topical treatments of anaesthetic creams for pain
- topical treatment with nitro-glycerine
- oral or topical blood pressure medications or injections of Botox to help relax the anal sphincter

Support workers should view the faeces of clients and report any bleeding or black bowel movements. Bleeding can be caused by something other than the above conditions and must be investigated.



DIVERTICULAR DISEASE

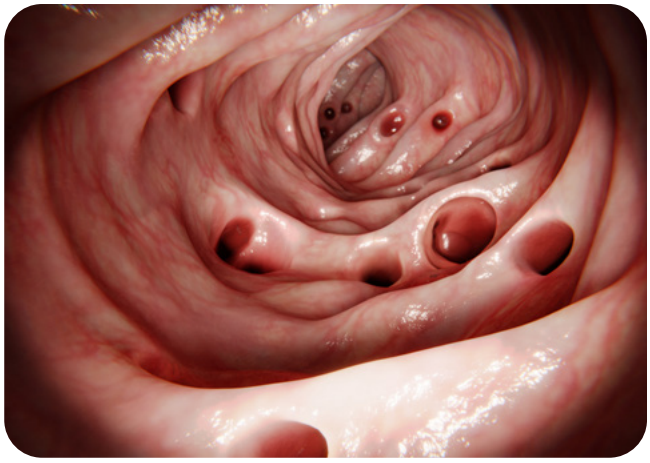
Diverticular disease can result from ongoing constipation that requires a client to strain repeatedly during bowel evacuation.

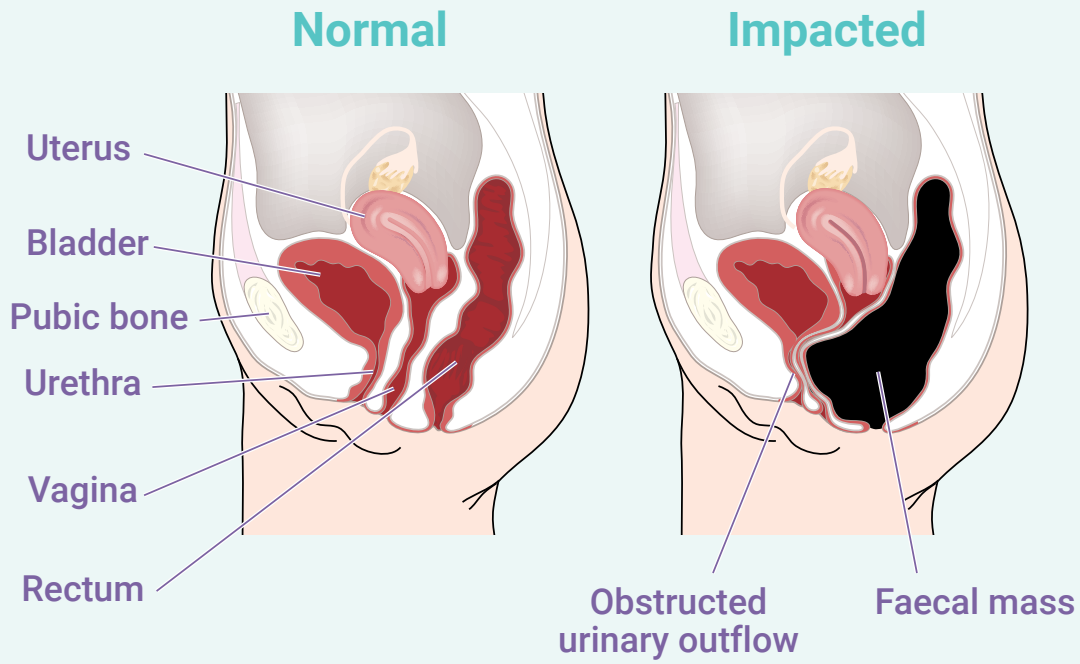
The large intestine is damaged by the increased pressure, which leads to small formations of sacs, known as diverticula, which can then become inflamed, a condition known as diverticulitis. On occasion, the diverticula can bleed and very rarely can rupture.

Signs or symptoms that a client may have diverticulitis include:

- pain in the abdomen
- constipation
- diarrhoea
- bloating
- nausea and vomiting
- fever and chills
- blood in the stool
- bleeding from the rectum
- constant and severe pain in the abdomen

Mild diverticulitis may be treated at home with dietary changes and antibiotics. Diverticulitis that creates further complications may require intravenous antibiotics, surgery to resect the unhealthy damaged part of the bowel or bowel resection that results in a colostomy.





FAECAL IMPACTION

Severe untreated constipation can lead to complete hardening of the faecal matter which entirely blocks the large intestine.

The resulting symptoms from the inability of stool to move through the large intestine include:

- abdominal cramping
- rectal pain
- strong urge to defecate with no result
- very watery mucus that oozes past the blockage
- difficulty to pass gas
- nausea and vomiting
- headache

Medical treatment that a doctor may initiate to resolve faecal impaction can include;

- oral medicated treatment
- an enema to soften stool and allow the muscular wave like movements called peristalsis to clear faecal matter
- manual dis-impaction; the doctor inserts gloved finger into the rectum to attempt to manually evacuate the hardened stool
- water irrigation where the doctor inserts a small hose into the rectum to flush out faeces

Without intervention, faecal impaction can lead to life threatening infection as the faecal impaction can tear the large intestine wall and leak faecal matter.

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 a variety 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:

VEGETABLES		FRUIT		CEREALS, PASTA AND RICE
• broccoli • spinach • carrots • pumpkin • sweet potato	• sweet corn • peas • green leafy vegetables e.g. lettuce • potato • cauliflower	• apple • banana • orange • pear • peach • apricots	• prune • figs • plums • kiwifruit • sultanas • dates	• brown rice • wild rice • brown pasta • wholemeal lasagne sheets • wholemeal, wholegrain, or grainy bread, pita or rolls • natural muesli • bran cereals • oat cereals
GRAINS AND LEGUMES		**NUTS AND SEEDS**		
• black-eyed beans • borlotti beans • butter beans • cannellini beans • chickpeas • haricot beans	• lentils • lima beans • mung beans • soya beans • split peas • barley • bulgur • buckwheat • kidney beans	• chia • quinoa • flax seed • sunflower seed • sesame seed • poppy seed • almonds	• cashews • hazelnuts • macadamia • peanuts • pine nuts • pistachios • walnuts	

PREVENTING CONSTIPATION

Paradoxically, too much fibre can cause constipation as it draws water from the bowel. The recommended fibre daily intake is 25-30g.

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. Some clients who have renal or cardiac issues may have fluid restrictions and preventing constipation can become a real challenge.

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 clients 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 client 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. People in some cultures achieve this position automatically when squatting or using squat toilets.

MANAGING CONSTIPATION

BOWEL TRAINING PROGRAM

People with a history of chronic constipation, impaction and incontinence may benefit from a bowel training program. A bowel training program is a behavioural program that is designed for people with a bowel disorder to re-establish control. A bowel training program will be under the direction of a qualified healthcare professional such as; a gastroenterologist, a physician with a background in colorectal disorders or a general medication or rehabilitation physician. A nurse who specialises in gastroenterology, rehabilitation or entero-stomal therapy may also have the necessary skills.

The program will manipulate factors within an individual's control such as food and fluid intake, exercise, and toileting times, 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 client must be able and willing to cooperate. Some clients are so convinced they need daily laxatives that they are afraid to go 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.

A healthcare professional will assess the client's bowel history including:

- past and present elimination bowel patterns
- medical history
- physical examination
- medication
- diet
- exercise

The assessment of the client should include a bowel symptom diary, which tracks episodes of voluntary and involuntary bowel movements and experience of the client whilst having bowel movement.

A food diary is another useful tool in conjunction with the bowel symptom diary, as it can help to determine the resulting characteristics of a bowel motion.

MANAGING CONSTIPATION

The bowel training program for a client on normal fluid intake would generally require:

- Explaining to the client the purpose of the program.
- Increasing fibre in the diet.
- Increasing fluids to 2500-3000ml per day, including hot drinks and clear fluids.
- Increasing exercise.
- Regulating a timed schedule of certain stimuli to promote peristalsis of the bowel e.g. hot drinks, exercise etc.

Note: Digital stimulation technique as a stimulus is sometimes used in the management of clients with Neurogenic Bowel for adults with Spinal Cord Injuries with only upper motor neuron bowel disorders. For more information refer to ACI NSW Agency for Clinical information 'Management of the Neurogenic Bowel for Adults with Spinal Cord Injuries'.

If suppository use is required:

- 30 minutes before a client's usual toileting time administer a suppository to stimulate peristalsis.
- When the client has the urge to defecate assist client to the toilet, allow privacy and adequate time, avoid rushing or abandoning the client.
- 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.

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 provides the client 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 symptoms lasting more than 7 days
- constipation alternates with diarrhoea
- bowel motions are very dark or tarry looking
- severe straining with no faeces being passed
- normal routine was one bowel faeces per day and has now been more than 3 days
- blood around the stool or problems with haemorrhoids
- client 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 client's needs.

TYPE OF LAXATIVE	WHAT THE LAXATIVE DOES	HOW LONG UNTIL A RESULT?	NAME OF LAXATIVES
Bulk forming	Very good as first line agents. Can interfere with the absorption of some medications. Increase bulk of the stool by absorbing water in the intestine making the stool softer and heavier. This promotes muscle contractions (peristalsis) to push the faecal matter through the system. Must ensure client has sufficient water intake or the faeces can become hard and impacted.	A few days	› Psyllium › Metamucil › Konsyl › Calcium polycarbophil › FibreCon › Methylcellulose fibre › Citrucel
Lubricants	Lubricates the stool to allow it to pass through the intestines. Should not be used long term as client can become dependent and deficient in vitamins A, D, E and K.	Within 6-8 hours	› Mineral Oil › Paraffin emulsion
Osmotic	Help to retain water in the intestines, softening the stool and sometimes increasing frequency of bowel motions.	30 mins up to 24-72 hours	› Lactulose › Macrogel › Magnesium sulphate › Sorbitol liquid › Sodium phosphate
Stimulants	Stimulant trigger the muscles in the intestines into the contractions contributing to peristalsis.	6-10 hours	› Bisacodyl › Dulcolax › Senna/sennosides › Senakot
Softeners	Create softer faecal matter, by adding water and fats into the stool. These are mostly used to prevent straining.	1-3 days	› Ducosate › Coloxyl › Agarol › Parachoc › Movicol

ENEMAS AND SUPPOSITORIES

Enemas and suppositories may be prescribed to treat constipation or other medical conditions. These work by stimulating the rectum to empty its contents. Enemas, such as Microlax, treat constipation by introducing fluid into the intestines through the rectum. The combination of the introduction of the nozzle into the rectum and the liquid from the enema softens the solid stool and helps to stimulate a bowel movement.

Glycerine suppositories attract water from the bowel down towards the mass of hardened stool to relieve constipation quickly and effectively. Glycerine suppositories also cause the muscles in the rectum to move more effectively in order to facilitate a bowel movement.

The process of these medications helps to pull out toxins and faeces from the body. It also causes an increase in the water levels of the faeces, thus helping in giving a proper colon cleanse and making the stools relatively soft, and the process of defecation less painful.

TYPE OF LAXATIVE	WHAT THE LAXATIVE DOES	HOW LONG UNTIL A RESULT?	NAME OF LAXATIVES
Osmotic agents	Softens the stool and/or pulls water from the body into the bowel	Up to 30 minutes (Microlax) 2-5 minutes (Fleet enema)	› Microlax enema › Fleet enema
Lubricant agents	Lubricates the rectum and anus	5-30 minutes	› Glycerol suppository
Stimulant agents	Stimulates the bowel muscles within the rectum to promote peristalsis	15-60 minutes	› Dulcolax suppository

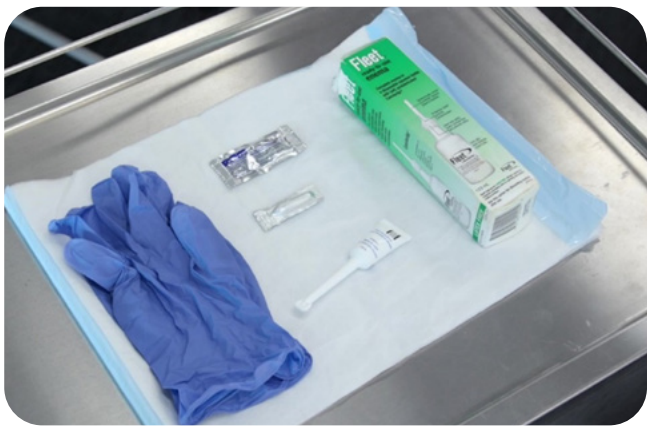
An enema or suppository should not be given if:

- the client is allergic to any of the ingredients listed
- out of date
- packaging is torn
- treating any other complaint unless prescribed by doctor
- 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 client is severely dehydrated

Contraindications to suppository and enema delivery include:

- recent colorectal surgery
- an abnormal growth around the anus and the opening of the rectum
- faecal impaction/obstruction
- bleeding and pain

A client who may have returned home with one of the above conditions, should have had their health care plan and medication charts reviewed, so that any administration of suppositories or enemas have very clear criteria to meet to ensure that it is appropriate and safe to administer.



ADMINISTERING AN ENEMA OR SUPPOSITORY

When administering an enema or suppository you need to consult and prepare the client.

Explain the procedure to the client and the effect of the suppository or enema. You will need to allow the client to urinate if needed.

Check client 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, single use packet)
- 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:

- Ensure that the bed is protected.
- Follow organisation's infection control procedures and wash hands, put on apron and gloves.
- Ensure the client's privacy and that they have immediate access to the toilet.
- Position client on their left side with their knees up towards their chest, this will aid relaxation and minimise resistance and discomfort on insertion.
- If the client is unable to lie on their left side, check with health care plan for alternative position/s or consult with doctor prior to undertaking procedure.
- Ask the client to relax, maybe breathe deeply.

Ensure enema or suppository is entirely lubricated before insertion using water-based lubricant.

- Separate the client's buttocks lubricate the anal area with water-based lubricant and gently push into the rectum at a 45-degree angle until there is slight resistance then straighten up enema or suppository.

- Client should be encouraged to remain lying for at least 15-20 minutes (or as per instructions).
- Dispose of gloves, bluey, packaging and other waste appropriately.
- Assist client to toilet when needed.
- Follow organisation infection control procedures and wash hands following procedure.
- 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 client to walk about if ambulant as this often helps promote peristalsis.

WARNING

When giving a suppository to a client, the person administering the suppository must have fingernails that are natural and short – they should be 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.

REPORTING

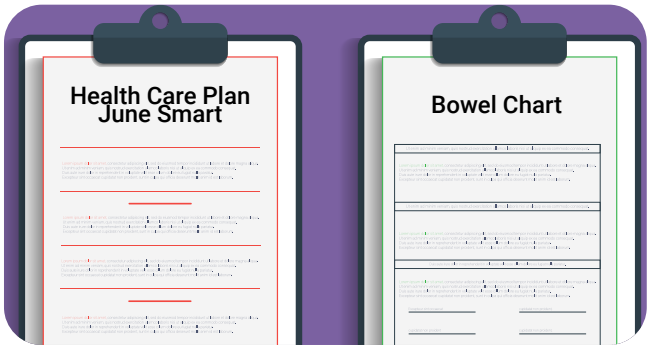
Support workers are responsible for documenting the care they provide and for gathering information about a client to assist in any review and development of care plans.

Regular monitoring of a client's bowel movements with a stool chart prevents constipation, urinary retention, and delirium in clients. Also, it is an audit leading to clinical effectiveness, efficiency and patient centred care.

Your company policy and procedures will demonstrate how to complete a bowel chart form that is used within your company.

Bowel charts should be:

- Completed after each bowel movement.
- Completed at least once daily if client hasn't opened their bowels. Your facility is likely to have a set time to record bowels for regularity for example at the end of each shift.
- Reviewed every 2-3 days to ensure client has sufficiently opened their bowels in a timely manner.



WHEN TO CALL THE DOCTOR

Any of the signs and symptoms listed below may indicate there is a medical issue with the bowels and the client must be seen by a doctor for further assessment and management.

- sudden weight loss
- severe abdominal pain
- pain or vomiting with constipation
- constipation lasting longer than 7 days
- constipation alternating with diarrhoea
- bowel motions very dark or tarry
- significant decrease in bowel movements
- severe straining with no movement
- blood around stool or problems with haemorrhoids

SUMMARY

Assisting a client with their effective bowel elimination patterns requires support, encouragement and effective communication.

To attain healthy regular bowel elimination, a client's health care plan should include a range of preventative measures such as; a high fibre diet, adequate fluid intake, varied exercise activities and correct toileting position measures.

If a client still experiences constipation, the health care plan should have management strategies such as oral or rectal laxative medications, reporting and recording procedures for support workers and specific signs and symptoms listed, indicating when a support worker needs to arrange an early medical review for the client.

NOTES

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
http://www.bladderbowel.gov.au/

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
www.dhs.vic.gov.au/home
http://www.dhs.vic.gov.au/health/older/toolkit/07Continence/index.htm

Better Health Channel, Victoria

Home Page: A-Z of Conditions: Constipation Fact Sheets, Conditions and Treatments, Healthy Living
www.betterhealthchannel.vic.gov.au/

The Joanna Briggs Institute, Faculty of Health Sciences,

The University of Adelaide, South Australia, 5005, Australia
Best Practice Management of constipation in older adults
http://www.joannabriggs.edu.au/pdf/BP_Book_Vol12_7.pdf

Royal Children's' Hospital, Melbourne

Fact sheet: Constipation in children
http://www.rch.org.au

Health InSite Health Direct Australia

http://www.healthinsite.gov.au/topics/Constipation

Department of Education and Early Childhood Development

Home Page keyword search: Constipation
http://www.education.vic.gov.au/

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

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- Epilepsy training and midazolam administration via intranasal and buccal routes
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- Positive behaviour support
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