



Minimizing bowel care. Maximizing Lives

A Clinical, Quality, and Economic
Perspective of Bowel Management in
a time of COVID-19

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Best Practices for Constipation, Fecal Incontinence and COVID-19 in Long Term Care

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Objectives

After this presentation, the LTC attendee will be able to:

1. Discuss the classification of constipation and appropriate nursing assessment, interventions, and medications to facilitate an effective bowel management program in a resident in the LTC setting.
2. Describe the Bristol Stool Scale and its' use in evaluation and planning with constipation and fecal incontinence.
3. Compare and contrast the causes, uses, mechanism of action and potential side effects of common modalities used in constipation and fecal incontinence.
4. Describe best practices for bowel management for coronavirus (COVID-19).





Program materials- on NADONA website includes:

- Enemeez and Enemeez plus Information
- Enemeez Sales Sheet
- Enemeez Quality of Care Bowel Protocol

Definitions-Constipation

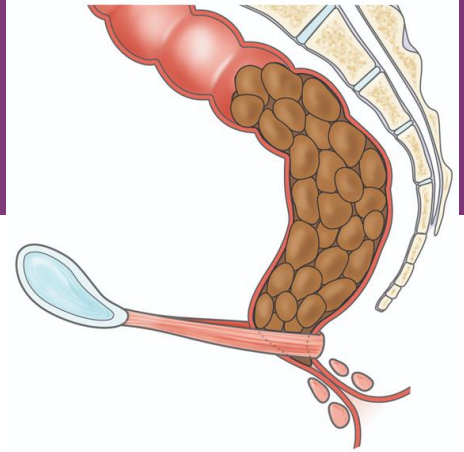
Constipation-the condition in which a person:

- has difficulty in comfortably passing a sufficient amount of stool;
 - passes less than 3 bowel movements' a week; &/or
 - has difficult bowel movements (straining).
-
- A condition in which there is difficulty in emptying the bowels, *usually* associated with hardened feces. Oxford Dictionaries · © Oxford University Press

Chronic constipation is:

The self report of 2 to 4 chronic symptoms (straining, hard or lumpy stools, incomplete evacuation, and infrequent stools). Choung et al. (2007)

Constipation





Incidence Of Constipation

- Constipation is the most chronic digestive complaint in the US
- More than 2.5 million visits to HCP each year
- Spend more than \$750 million each year on OTC laxatives
- In LTC facilities, laxatives are the most highly prescribed medications approx. 75%
- Incontinence is the second leading cause of admissions to long-term care facilities
- In community over 65 , 50% estimated to use laxatives chronically
- Women over 50- 2 -3 times more women likely to report constipation to their HCP.

- 
- Nhadm.--

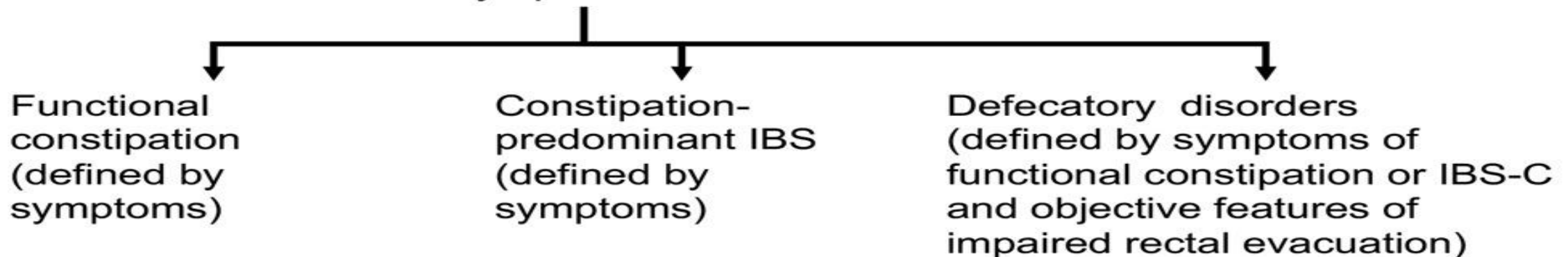
Constipation-Classification



AGA criteria - symptoms, anorectal tests, and colonic transit



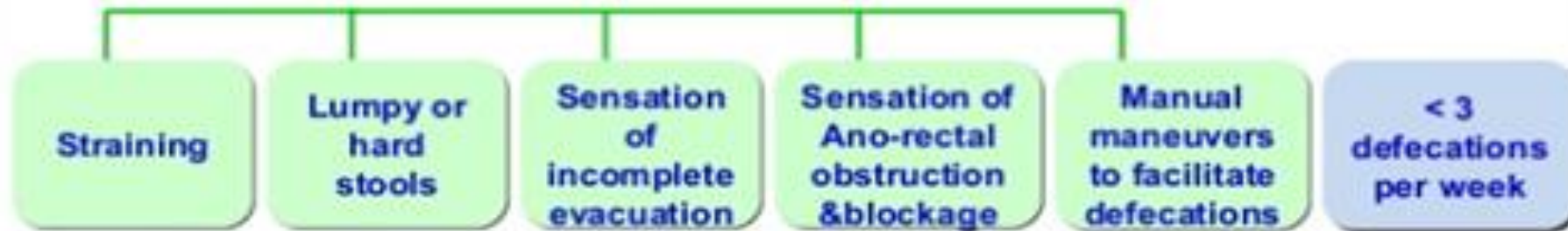
Rome IV criteria - symptoms and anorectal tests



Rome IV Chronic Constipation

☐ Chronic constipation must include 2 or more of the following

(During at least 25% of defecations)



☐ Loose stools are rarely present without the use of laxatives

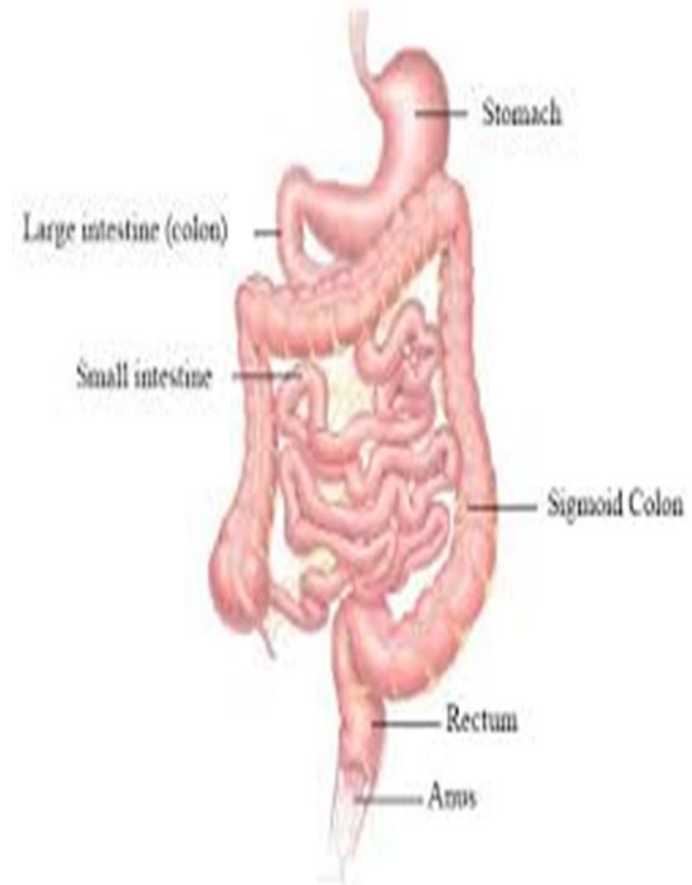
☐ Insufficient criteria for irritable bowel syndrome

*Criteria fulfilled for the last 3 months with symptom onset at least 6 months prior to diagnosis

!Take home point: Ask these questions for assessment

Anatomy

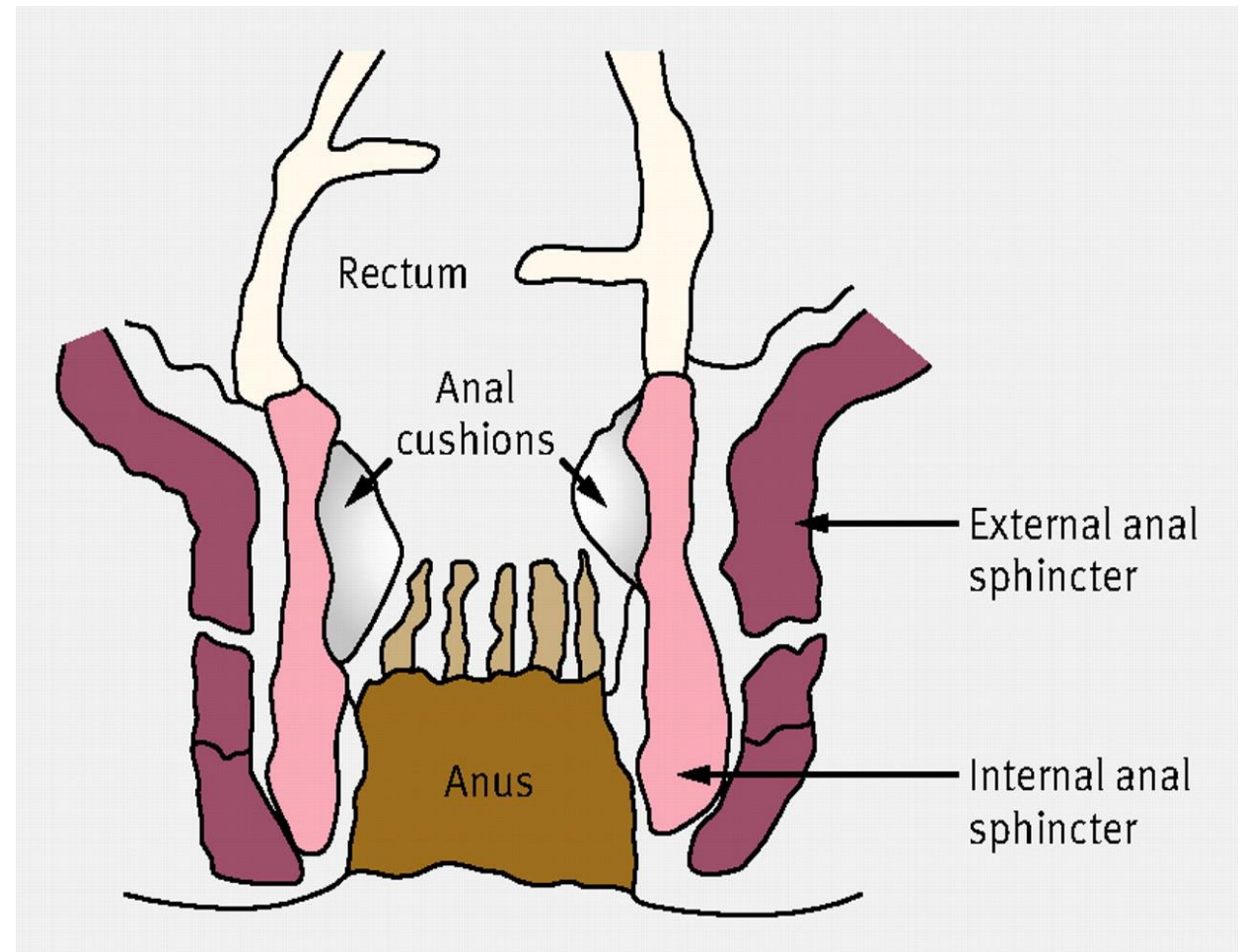
- Ascending and transverse colon absorb H₂O and electrolytes
- Descending and sigmoid colon stores fecal matter until eliminated
- Smooth muscle of colon contracts and relaxes in response to distension and mixing movements occur
- Contents of colon enter the rectum usually q am
- Spinal reflex to defecate occurs and the anal sphincter relaxes or contracts with pelvic and abdominal muscle movement



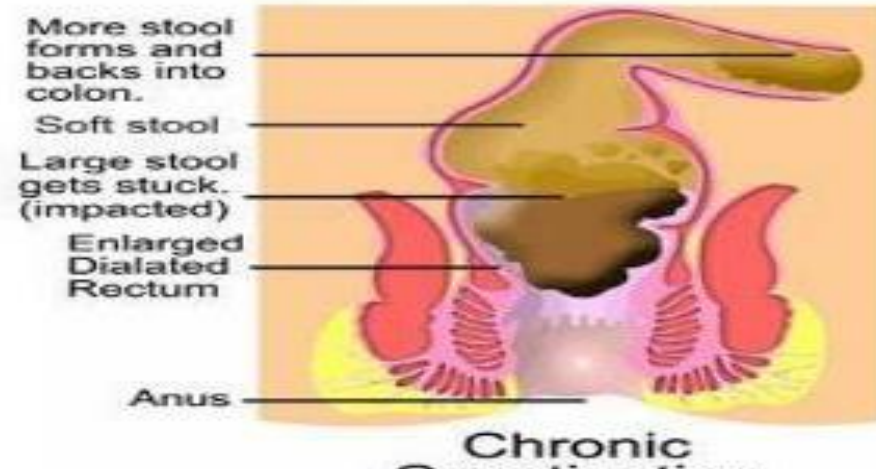
Constipation-Anatomy

-is approximately 1.2 m long (4 ft.) and is bounded by the ileocecal sphincter at its origin and by the anal sphincter at the perineum (Rothenberger & Orrom, 1991).

- colon wall has several layers: the inner mucosal lining, the submucosa, and an outer layer of muscle that has two divisions—the inner layer, which is a continuous sheath of circular smooth muscle, and the outer longitudinal layer (Rothenberger & Orrom, 1991).



Physio-pathology Chronic Constipation



Risk Factors for Constipation



- :
- Female sex, older age, inactivity, low income, and low educational level and low fluid/fiber intake.
- **Female**-The incidence is **3X** higher in women, and women are twice as likely as men to schedule physician visits for constipation.
- Studies have shown that bowel transit time in women tends to be slower than in men, and many women experience constipation during their menstrual period.
- **Nonwhites**-Constipation is 1.3 times more likely to occur in nonwhites than in whites and is considerably more common in families of low socioeconomic status.
- Medicare beneficiary data suggest that in addition to low socioeconomic status, environmental risk factors for constipation may include living in *rural* areas and in *colder* temperatures.





Common Causes of Constipation

- Neurologic Disorders (Neurogenic Bowel Dysfunction-NBD)-
Parkinson's Disease and medication for, Stroke, SCI)
- Myopathic Disorders
- Depression
- General disability
- Poor mobility
- Colon disorders-diverticulosis/diverticulitis, colon cancer,
- Damage to sacral nerve- trauma, childbirth

Medications Contributing to Constipation (Polypharmacy)



- **NSAIDS**-ibuprofen, Motrin and naproxen (Aleve)
- **Antidepressants** including the selective serotonin reuptake inhibitors (SSRI's- fluoxetine/Prozac or tricyclics (amitriptyline/Elavil).
- **Anticholinergics** (*bladder control*)
- **Antacids** containing calcium or aluminum such as Tums, & *Iron* pills
- **Allergy medicine** such as antihistamines (diphenhydramine)
- **Certain blood pressure meds**, including Ca channel blockers (like verapamil /Calan SR, diltiazem (Cardizem),and nifedipine (Procardia) and beta blockers - end in "lol"
- **Psychiatric medications** like clozapine and olanzapine/Zyprexa
- **Anticonvulsants/seizure meds** such as phenytoin/Dilantin and gabapentin
- **Antinausea** meds- ondansetron/Zofran



Opioid Induced Constipation (OIC)

- *-is a different type of constipation.*
- -OIC occurs when opioids attach to the mu receptors (pain) in your bowel
- -OIC can last the entire time you take an opioid for long lasting chronic pain, other than cancer related.
- -Opioids include medications like codeine, hydrocodone, morphine, oxycodone, fentanyl or tramadol.
- Symptoms of OIC include: (same as any constipation but cause and tx different)
- -Fewer than 3 spontaneous BMs in a week
- - Unable to have a *complete* bowel movement,
- - Feeling like you need to go but not being able to,
- - Straining to have BM
- Treatment
- -OTC laxatives may not work for everyone with OIC
- MOST laxatives are labeled that if you need for more than one week, to see your doctor.
- Medications; Movantik (Naloxegol),-may have symptoms of opioid withdrawal, including sweating, chills, diarrhea, stomach pain, anxiety, irritability and yawning.

Constipation- Why do we care?



Role Responsibility

RESIDENT CARE AND QUALITY OF LIFE

- Ensure that nursing services are planned, implemented, and evaluated to maximize resident **quality of life and quality of care.**

CDONA
means
Certified Director of Nursing
Administration
by allacronyms.com



ADON
is a shorter form of
Assistant Director of
Nursing
by allacronyms.com





Quality of Life/Care -Regulations/Laws/Standard of Care

Regulations/Laws/Standards of Care for LTC/Aging CFR/SOM F690 (2017)

The facility **must** ensure that a resident who is continent of bladder and **bowel** on admission receives services and assistance to maintain continence unless his or her clinical condition becomes such that continence is not possible to maintain.

The increased abdominal pressure associated with constipation contributes to bladder instability and can result in bladder incontinence.

Avoidable vs. Unavoidable?

- **Assessment**
- **Planning**
- **Interventions**
- **Evaluation**
- **Planning**
- **Reevaluation**



Quality of Life



- Pain, discomfort, bloating
- Lack of appetite
- Nausea
- Fatigue
- Irritability
- Change in behaviour
- Haemorrhoids, prolapse
- Fecal impaction , diarrhea

Social isolation, depression



Constipation-Adverse Effects-Hemorrhoids (Piles)

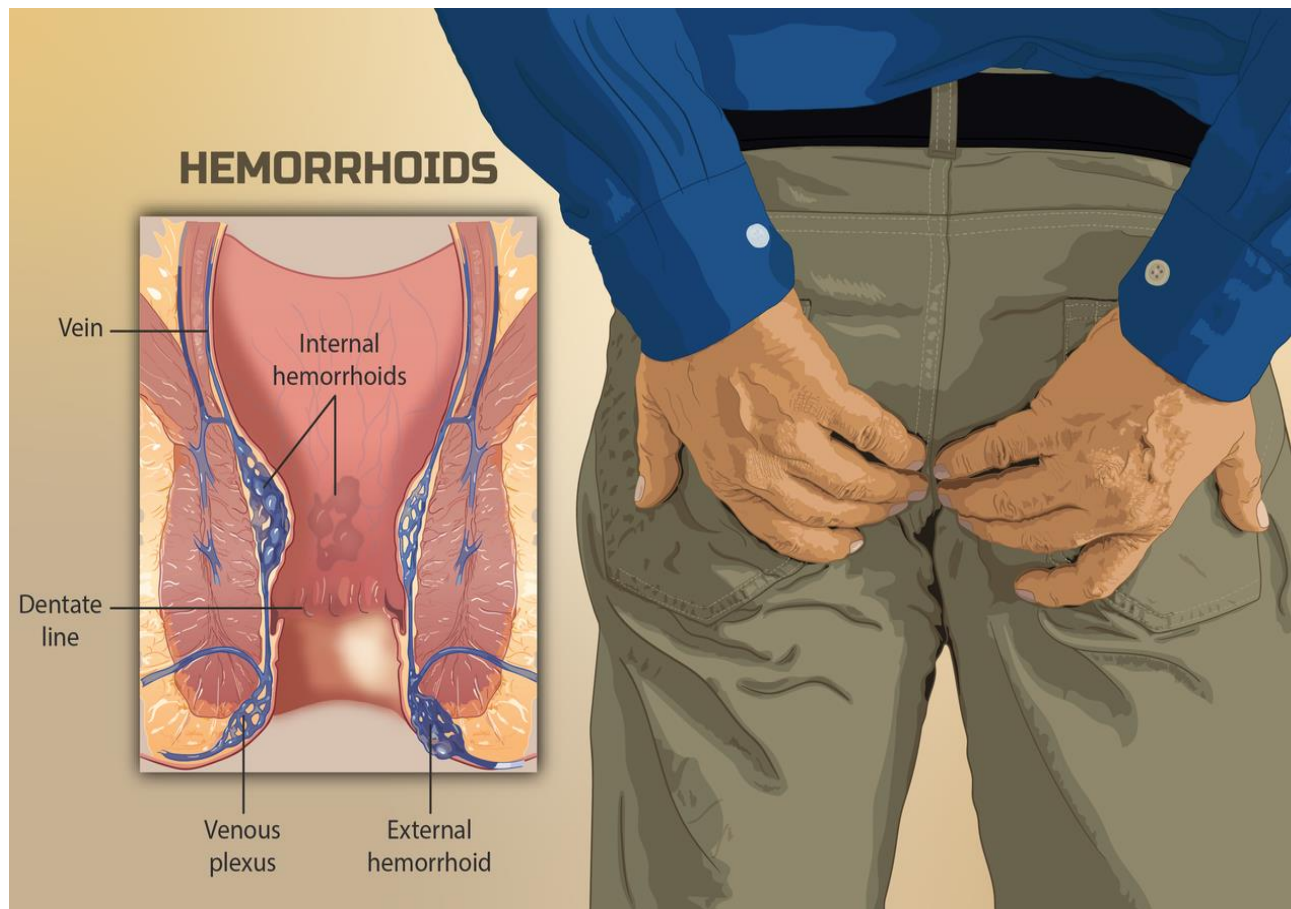


Table 1: Hemorrhoidal Disease Grade

Hemorrhoidal disease grade	
1st Degree	The hemorrhoids bulge slightly into the anal canal beyond the dentate line. This happens during straining defecation.
2nd Degree	The hemorrhoids prolapse through anus but they reduce spontaneously.
3rd Degree	The hemorrhoids prolapsed through anus but manual reduction is required to insert them into anal canal.
4th Degree	The hemorrhoids prolapse, cannot be reduced, there is bleeding and increased risk for strangulation.

Fecal Impaction-Potential Complications of Constipation

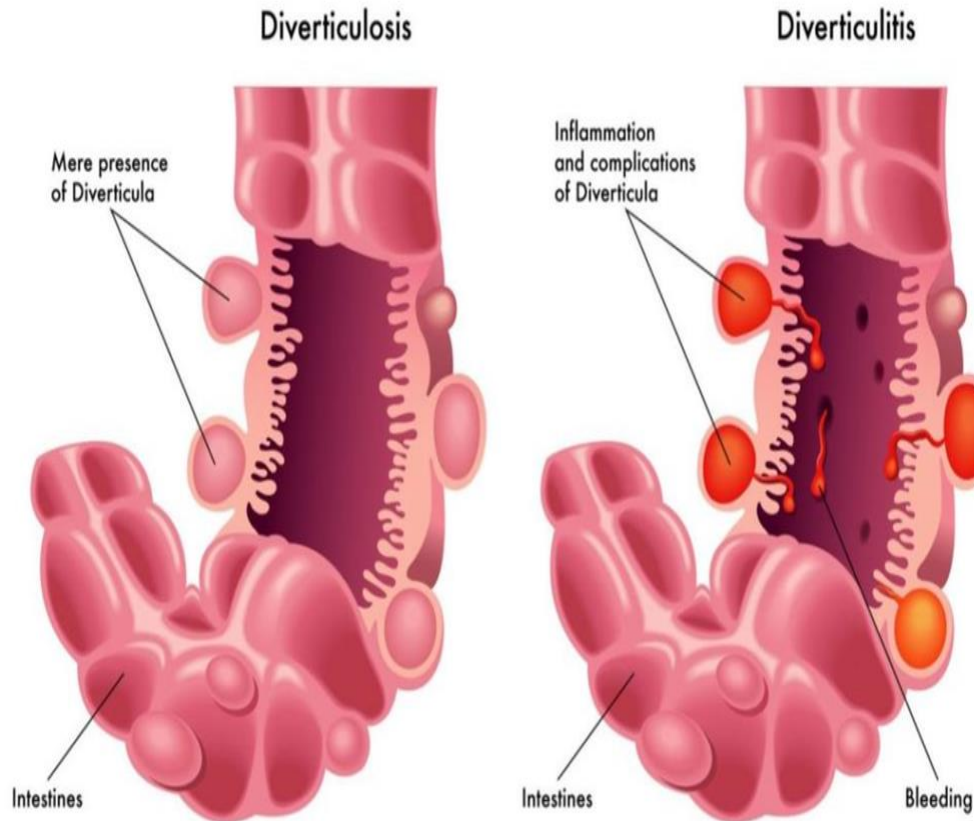


IMPACTION (CONSTIPATION)

- Constipation ↑ in older people > 60 y
 - Regular use of laxatives
 - Associated : anxiety, depression
poor health perception
 - Complication : fecal impaction (1)
fecal incontinence (1)
urinary retention (2)
sigmoid volvulus (2)
 - ↑ morbidity : intestinal obstruction.
- Stercoral ulceration: rectal “pressure” ulcers from impacted stool and obstipation
 - Megacolon: dilation of the colon that is not caused by obstruction (rectosigmoid diameter >6.5 cm)
 - Bowel perforation (new onset or from above etiologies)

Diverticular Disease (Diverticulosis/Diverticulitis/Perforation)

- A condition of the colon, often affecting the sigmoid
- Mostly found in the elderly
- Associated with a low fibre diet, dehydration, constipation and straining to defaecate
- The elderly often present with diverticulitis, inflammation and infection of the colon



Prevention constipation
Diverticulosis Diet



Rectal prolapse

Clinical Features


- Something coming out per rectum during defecation
 - May even on standing ,walking or coughing
- Red
- Fecal incontinence (75%)
- May reduce spontaneously or required digital reduction



Figure 68.9 Full-thickness rectal prolapse (excess of G.D. A. Bombay, India).

Complete Prolapse

- all layers of the rectal wall involved
- usually associated with a weak pelvic floor and is as much as 10-15 cm.
- Less common
- more common in elderly people.
- Common in female (6:1)
- Fecal incontinence (approx.50% of adults)



Fecal Incontinence and the Increased Risk for Pressure Ulcers & Incontinence Associated Dermatitis



Fecal Incontinence- Definition

- **AKA-Bowel Incontinence, Anal Incontinence**
- **Definition-**
- The **Unintentional** loss of liquid or formed stool and/or gas.
- **Description-**
- Ranges from occasional leakage to a complete loss of bowel control
- True anal incontinence is the loss of anal sphincter control leading to the unwanted or untimely release of feces or gas

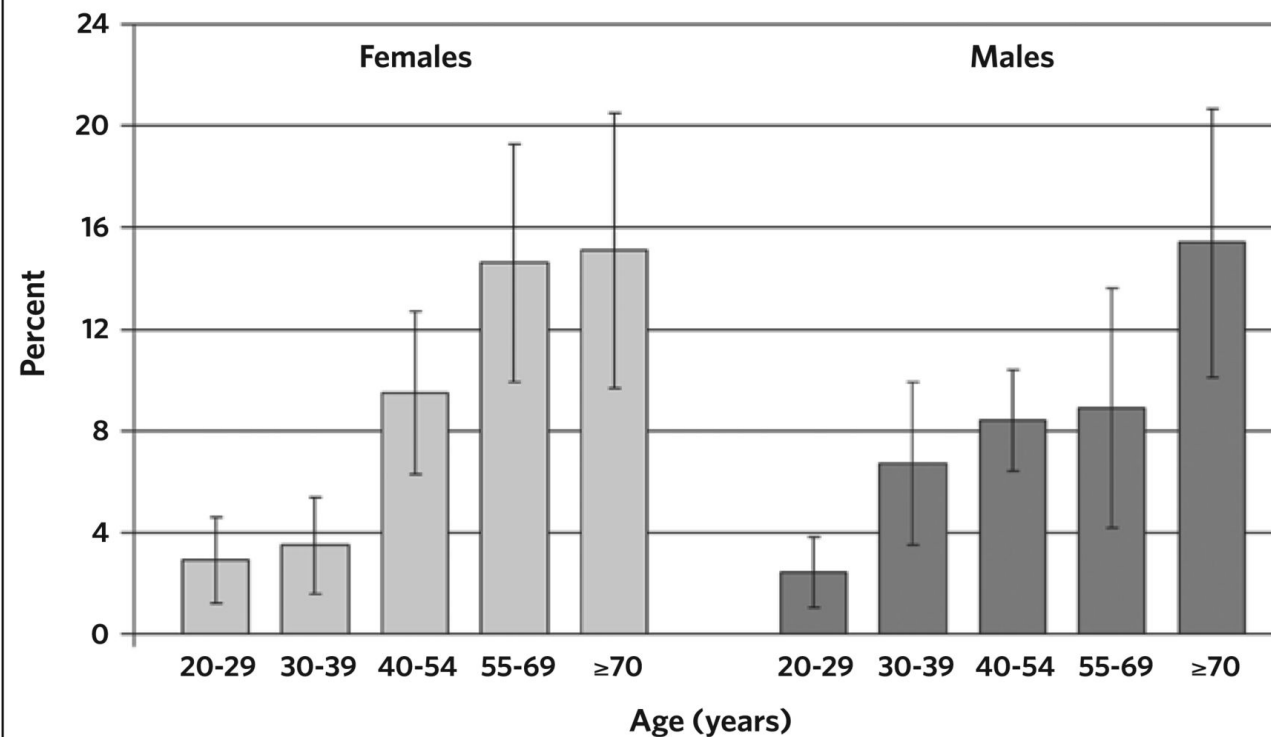


Epidemiology of FI

- Community-dwelling older adults (>65) with bowel or bladder incontinence:
 - 35% of women
 - 20-30% of men
- Assisted living environments
 - 30-50% of women
 - 30% of men
- Long-term care (nursing home)
 - > 50-78% of men and women

Prevalence Men vs. Women -FI

FIGURE 1.
Prevalence of Fecal Incontinence by Age Group in Female and Male Subjects



Note. Bars represent 95% confidence intervals.
Source: Reprinted with permission from Whitehead WE, et al [1].

Causes of Fecal Incontinence

Risk Factors for FI



- Age >65
- Female-complications of childbirth,
- Women who receive hormone replacement therapy
- Dementia- worsens – as stages worsen
- Physically disabled
- Nerve damage –long standing diabetes, not controlled
- HgA1c-<7.0

HELPLINE: 888882 888884



Effects of Fecal Incontinence

Bowel & Bladder incontinence has significant negative impact on both overall and health-related quality-of-life.

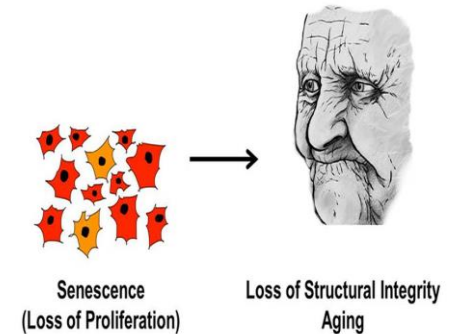
- Social isolation, Depression, Psychological distress
- Increased caregiver burden, Skin inflammation / breakdown
- Sleep disturbance, Increased risk urinary tract infection (UTI), Cost related to management of incontinence
- Increased risk of falls and fractures related to urgency / frequency, nocturia, impaired mobility and vision changes
- Increased risk of mortality associated with falls, fractures and skin breakdown

Fecal Incontinence and the Risk of Pressure Ulcers

- "...Patients with fecal incontinence were 22 times more likely to have pressure ulcers than patients without fecal incontinence." ¹
- "...The odds of having a pressure ulcer were 37.5 times greater in patients who had both impaired mobility and fecal incontinence than in patients who had neither."¹
- Fecal incontinence in hospitalized patients increases the risk of nosocomial infections and the development of pressure ulcers, increases mortality, and morbidity. ²

Fecal Incontinence Affects Skin Integrity

- The mean pH of skin ranges from 5.5 – 5.9.
- Normal feces is alkaline, with a typical pH of 7.0 to 7.5, contributing to an abnormal skin pH in incontinent patients.
- Exposure to stool changes the pH of the skin and impairs the integrity of the barrier formed by the skin cells, exposing the skin to harmful digestive enzymes.
- Overgrowth of microorganisms leads to skin irritation or infection, further weakening the skin's defense. Coupled with friction and pressure can lead to erosions and pressure ulcers, particularly in skin that is already compromised by prolonged exposure to stool and urine.





Pressure Ulcers Can Be Fatal and Can Be Avoidable?

Redelings, et.al. looked at the number of deaths resulting from pressure ulcers between 1990-2000.

- Pressure ulcers can lead to fatal secondary infections such as septicemia and are an important cause of preventable mortality in the United States.
- There were 105,734 deaths or 3.88 deaths per 100,000 population.
- In 19% of these deaths, pressure ulcers were reported as the underlying cause.
- Septicemia was reported in 75% of the deaths with pressure ulcers identified as the underlying cause.
- Operating time for a pressure ulcer may be up to 3 hours, and blood loss may be between 500 and 1,500ml.
- Mortality rate is between 50-70% for persistent bacteremia associated with wound infected pressure ulcers.



Regulations for LTC-Avoidable vs. Unavoidable?

- Will look at ALL **possible** contributing factors will be looked at-
- Diet/ hydration, activity,
- **Bowel and bladder incontinence,**
- Turning/positioning/pressure relief/pressure shifts
- Surfaces/ cushions/

Incontinence Associated Dermatitis



Skin condition commonly associated with incontinence. Skin irritation and inflammation related to exposure to urine and feces. Additional risk factors:

- Diaper use
- Bed bound / immobility

Incontinence Associated Dermatitis (IAD)



Pressure Ulcer vs. Pressure Injury (IAD)



PRESSURE ULCER¹

- ▶ Located over a bony prominence.
- ▶ Over coccyx (tailbone) or ischia (butt bones); they are usually round or oval shaped.
- ▶ Over sacrum, may be butterfly shaped or oval if mostly on one side.
- ▶ Well defined edges—no satellite lesions.



IAD DUE TO CONTACT WITH URINE OR FECES¹

- ▶ Location is where the skin lays in or on urine or feces; not only over a bony prominence.
- ▶ Early injury is bright red, then bright red and weepy.
- ▶ Post-acute skin is purplish and very dry, peeling like a sunburn.
- ▶ No satellite lesions unless also has fungal.

Pressure injury

Bottom
Up

Top Down

Shear & Friction



Erosion of the skin occurs frequently and probably attributable to friction created by moving moist or saturated pads or clothing over irritated skin; or to damage from digestive enzymes present in liquid or solid stool.

Unstageable Pressure Ulcer



Incontinence, immobility, increased moisture, pressure and malnutrition causes serious skin conditions/wounds.

Skin Treatment Products



MEDEXLINE
healthcare supplies
1-800-674-4307

Product Gallery



VASHE

**3 M Advanced skin protectant.-
elastomeric polymer- 3 day,
enables attachment to wet, weepy
skin, repels irritants, can stay on 3
days- about \$13.00.**



**3M Cavilon
Advanced Skin...
\$13.51**



Resident/Patient Assessments

Goal: An effective bowel management program that prevents constipation and fecal incontinence

Navigating and Effective Bowel Management Plan



6 questions to ask? Chronic Constipation- how long?

Straining

Lumpy or
hard
stools

Sensation
of
incomplete
evacuation

Sensation of
Ano-rectal
obstruction
& blockage

Manual
maneuvers
to facilitate
defecations

< 3
defecations
per week

Bowel (Constipation and Incontinence History)



- **Medical History?**
- **Frequency?**
- **Sensations?**
- **Medications?**
- **Amount?**

Bowel Assessment

The most essential step is determining the etiology or cause

- Usual bowel pattern and measures currently used
- Hx of problem
- Ability to sense urge to defecate
- Daily fluid and fibre intake
- Relevant medical/surgical hx
- Functional abilities
- 7 day bowel record
- Physical assessment





What are we going to do with this Information?

Consistency of Stool Drives Interventions

- **Documentation-“moderate amount, formed”**
- **Look at each stool!**
- **Document on diary/ADLS or bowel record,**
- **amount, consistency**
- **Revise bowel management plan/individualize based on results**
- **Facility protocol to drive but needs to be individualized**



Stool Consistency and Texture/Transit Time

- Stool that is formed and semi-soft goes through bowels easier and quicker- decreased Transit Time and less hemorrhoids, diverticulosis, nausea. Transit Time Assessment/history/diary
- Description of timing, frequency, consistency/texture,-all on same page and using same/similar terminology. (Bristol Stool Chart or similar)
- Amount- large, moderate, small- try and define these.
- Look at each movement.
- Adjust diet, meds, regimen, accordingly.





Bristol Stool Chart


Oloomi-Type 0- Hard, big ball, trunk




Type 1  Separate hard lumps, like nuts (hard to pass)

Type 2  Sausage-shaped but lumpy

Type 3  Like a sausage but with cracks on its surface

Type 4  Like a sausage or snake, smooth and soft

Type 5  Soft blobs with clear-cut edges (passed easily)

Type 6  Fluffy pieces with ragged edges, a mushy stool

Type 7  Watery, no solid pieces. **Entirely Liquid**

Oloomi-Type 8

Watery, clear



VEGETABLE
WONTON SOUP



Egg drop soup



**SLOW
TRANSIT**

**RAPID
TRANSIT**

Hard

Soft

Bowel Care Patient Assessment Form

Page 1

Note:

- This form is offered as a sample only and criteria for assessment should be determined by staff members at your facility. A listing of assessment areas is offered.
- It is important to determine that diarrhea is not overflow due to constipation.
- A three day food and fluid intake history should be a practical approach for assessment.

A. Description of bowel patterns

B. Cognitive and functional ability

- Orientation in time
- Orientation in space
- Functional ability

C. Altered ability to defecate

Disclaimer: Bowel protocol was designed with input from healthcare professionals and physicians who have consulted with Enemeez® over the past ten years. The materials contained in this "Bowel Care Assessment and Protocol Tools for Acute Care Patients", are for reference purposes only. Each healthcare facility shall employ their own practice guidelines. Enemeez Inc. does not assume responsibility for patient care or the accuracy of the processes presented. Copyright 2012 Enemeez Inc.

A. Description of bowel patterns:

Exact time of daily evacuation:

Number of incontinent stools daily:

Number of mucosal discharge episodes daily:

Stool Consistency:

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

B. Cognitive and functional ability:

The following general assessment is to be performed on patients that present with a good degree of cognitive ability. A more complete assessment may be required for those patients that present with some forms of brain injury or disease states.

ORIENTATION IN TIME:

- What is the year?
- What is the season?
- What is the month?
- What is the day?
- What is the day of the month?

ORIENTATION IN SPACE:

- In which state are we in?
- In which city are we in?
- What is this building we are in?
- Which floor are we on?

FUNCTIONAL ABILITY:

- Change in activity in the last two weeks? Yes or No
- Change in privacy or accessibility to the toilet? Yes or No

Explain:

C. Altered ability to defecate:

- ☐ Neuromuscular
- ☐ Hirschsprung's Disease
- ☐ Autonomic Neuropathy
- ☐ Chagas Disease
- ☐ Intestinal Pseudo Obstruction
- ☐ Cerebral Tumors
- ☐ Meningoceles
- ☐ Tabes Dorsalis
- ☐ Shy-Drager Syndrome
- ☐ Dermatomyositis
- ☐ Progressive Systemic Sclerosis
- ☐ Diabetic Neuropathy
- ☐ Parkinson's Disease
- ☐ Spinal Cord Injury
- ☐ CVA
- ☐ Multiple Sclerosis

Bowel Care Patient Assessment Form

Page 2

Note:

- This form is offered as a sample only and criteria for assessment should be determined by staff members at your facility. A listing of assessment areas is offered.
- It is important to determine that diarrhea is not overflow due to constipation.
- A three day food and fluid intake history should be a practical approach for assessment.

D. Constipation Assessment Scale

- Identify if there is no problem, some problem or severe problem.

E. Diet and Fluid

- Number of Fluid Ounces per day
- Daily Fiber intake

F. Medications the patient is taking

<input type="checkbox"/> Traumatic Brain Injury			
<input type="checkbox"/> Dementia			
<input type="checkbox"/> Sedation			
<input type="checkbox"/> Autonomic Failure			
<input type="checkbox"/> Hypothyroidism			
<input type="checkbox"/> Opioid Use			
<input type="checkbox"/> Post-Operative Complications			
<input type="checkbox"/> Coma			
<input type="checkbox"/> Vegetative State			
<input type="checkbox"/> Other			
Additional Comments:			
D. Constipation Assessment Scale	No Problem	Some Problem	Severe Problem
1. Abdominal distention or bloating			
2. Change in amount of gas passed rectally			
3. Less frequent bowel movements			
4. Oozing liquid stool			
5. Rectal fullness or pressure			
6. Rectal pain with bowel movement			
7. Small volume of stool			
8. Unable to pass stool			
Scoring: Add symptom score for a total score that ranges between 0 and 16. Results: 2-6 = mild to moderate constipation 7-10 = moderately severe constipation 11+ = severe constipation Source: McMillan SC, Williams FA. Validity and reliability of the Constipation Assessment scale. Cancer Nurs. 1989;12:183-188.			
E. Diet and Fluid:			
Fluid per day in ounces:			
Fiber intake in grams:			
F. Medications:			
<input type="checkbox"/> Opioids			
<input type="checkbox"/> Drugs with anticholinergic action:			
<input type="checkbox"/> Anticholinergics			
<input type="checkbox"/> Antidepressants			
<input type="checkbox"/> Phenothiazines			
<input type="checkbox"/> Haloperidol			
<input type="checkbox"/> Antacids			
<input type="checkbox"/> Antispasmodics			
<input type="checkbox"/> Antiemetics-5HT3 Antagonists			
<input type="checkbox"/> Diuretics			
<input type="checkbox"/> Anticonvulsants			
<input type="checkbox"/> Iron			
<input type="checkbox"/> Antihypertensives			
<input type="checkbox"/> Chemotherapy Agents – Vinca Alkaloids, 5-Fluorouracil, Mitomycin			
<input type="checkbox"/> Antibiotics			
<input type="checkbox"/> NSAIDs – Diclofenac, Indomethacin			
<input type="checkbox"/> Iron Preparations			
<input type="checkbox"/> Disaccharide Containing Elixirs			

Bowel Care Patient Assessment Form

Page 3

Note:

- This form is offered as a sample only and criteria for assessment should be determined by staff members at your facility. A listing of assessment areas is offered.
- It is important to determine that diarrhea is NOT overflow due to constipation.
- A three day food and fluid intake history should be a practical approach for assessment.

G. Physical Issues

H. Abdominal examination

I. Rectal examination

G. Physical Issues:

- ☐ Advanced age
- ☐ Immobility
- ☐ New spinal cord injury
- ☐ Lack of exercise
- ☐ Poor dietary and fluid intake
- ☐ Changes in life routine
- ☐ Ignoring the urge to defecate
- ☐ Dementia
- ☐ Abnormal toileting position
- ☐ Inconsistent and insufficient toileting time
- ☐ Lack of privacy

H. Abdominal:

- ☐ Distention
- ☐ Visible peristalsis
- ☐ Bowel sounds
- ☐ Masses
- ☐ Rigidity
- ☐ Tenderness

I. Rectal: *Perform on patients in the left lateral position

Perform anal test, appearances of:

- ☐ Fissures
- ☐ Hemorrhoids
- ☐ Masses
- ☐ Stool
- ☐ Prostate size
- ☐ Perianal ulceration
- ☐ Anal sphincter tone
- ☐ Anterior mucosal prolapsed
- ☐ Anal stenosis

Suggested Testing: (*patients with ongoing constipation issues)

- **Laboratory:** Fecal occult blood testing (FOBT); thyroid function studies; serum electrolytes; serum glucose; and complete blood count (CBC).
- **Radiographic diagnostic testing:** Such testing of the kidney, ureter, and bladder (KUB) may be indicated to rule out an organic cause of constipation. (Constipation may present with clumps of rounded masses with entrapped gas and varying degrees of dilated bowel)
- **Additional evaluation** is indicated if there is a positive occult blood test, weight loss, anemia, and an onset of constipation that cannot be attributed to lifestyle changes. Appropriate tests include a barium enema, a colonoscopy, and sigmoidoscopy.
- **Cognitive Testing** (Patient presenting with some degree of impaired cognitive ability.) The provided links are for reference only:
http://www.alz.org/professionals_and_researchers/14306.asp
<http://www.mrbraintest.org/2011/04/cognitive-assessment-and-rehabilitation-for-traumatic-brain-injury-sbi/>

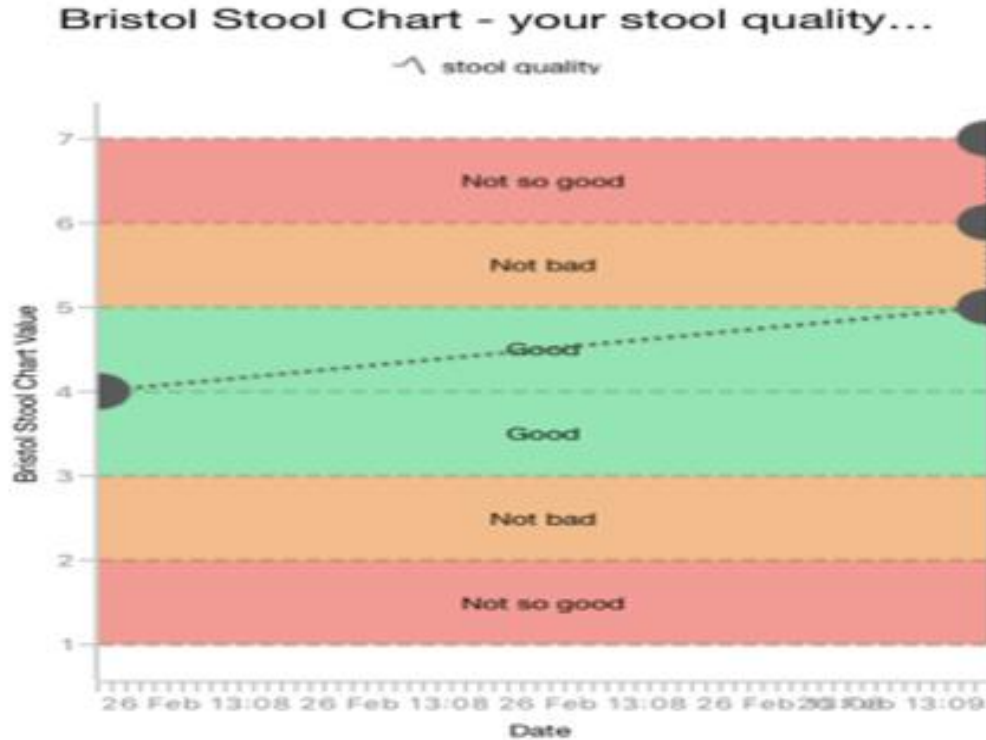
Getting information-DocumentationⓈOld fashioned way!!!!!!

Date	Time of Evacuation	Total Time for Bowel Care	Fluid in ML	Fiber in Grams	Stool Consistency Bristol Stool Chart Type 1-7	# of Incontinence Episodes	Time Spent on Digital Stimulation	Bowel Medication(s) Used

Disclaimer: Bowel protocol was designed with input from healthcare professionals and physicians who have consulted with Enemeez® over the past ten years. The materials contained in this "Bowel Care Assessment and Protocol Tools for Acute Care Patients", are for reference purposes only. Each healthcare facility shall employ their own practice guidelines. Enemeez Inc. does not assume responsibility for patient care or the accuracy of the processes presented. Copyright 2012 Enemeez Inc.

If there isn't an app for it- it must not be important! Internet Resources:free

- BSC-www.bristolstoolchart.net- mobile device! Track your stool quality over time with the Bristol stool chart mobile app!





Clinical comparisons of Common Medications used for Bowel Care

Bowel Management Program (BMP, not BP)

A BMP will :

- be implemented for the individual who experiences or is at risk of experiencing bowel incontinence or retention/constipation.
- will be individualized for each patient, requiring the least amount of intervention (i.e.: high fiber diet and dietary supplements, medications, mini-enemas, digital stimulation*, etc) to achieve acceptable results (EFFECTIV
- Establish a daily predictable bowel care time(how often? Time of day?
- Follow recommended nutrition and fluid requirements (at least 20-35 grams of fiber daily.
- Fluid



Stepwise Approach

Stepwise Approach to Constipation

Step 1 – Fluids, Fibre, Exercise and
Toileting Regimens

Step 2 – Use with CAUTION.
Bulk-forming laxatives and
stool softeners.

Step 3 – Osmotic laxatives

Step 4 – Stimulants

Step 5 –
Suppositories
and
Enemas



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Adapted from Sanburg, A.L.,
McGuire, T.M., & Lee, T. (1996).
In Folden, SL et al. 2002.
Rehabilitation Nursing
Foundation (RNF) Practice
Guidelines for the Management
of Constipation in Adults

Sip and go



Swallowing problems? Dry mouth?
Speech therapist consult?
Dysphagia eval?
Any symptoms-coughing, wet voice, silent?



Liquids- are all liquids good?

Stepwise Approach to Management of Constipation: (Adapted from Sanburg, McGuire, & Lee, 1996*)

Taking a least evasive approach or a stepwise approach to management of a neurogenic bowel or constipation is recommended, keeping in mind the most natural form of elimination is the best long term approach. Consideration of maintaining healthy rectal mucosa is paramount to patient quality control measures when using rectal stimulant remedies i.e. bisacodyl.

Daily

Daily: Encourage Exercise-Fluid-Fiber-Toileting Regimen (Same time each day, morning recommended)

- 64-96 ounces of Fluid daily as tolerated (water, prune juice, juices etc.)
- 20-35 grams of Fiber
- Hot beverage prior to scheduled toileting regimen

Neurogenic Bowel: Incorporate daily for regimented bowel program

Note: Certain antineoplastics or specific chemotherapy agents can cause either constipation or diarrhea. If individuals experience diarrhea, hold the laxatives temporarily until diarrhea subsides.

Day 1-2

Stool Softeners: If patient exhibits hard stools, inadequate amount of stool or no bowel movement. Docusate sodium(DSS) can be taken orally or rectally. For these drugs to be most effective, it is essential that a person consumes at least 1 to 2 liters of fluid per day.

- Docusate sodium oral 100-400mg Daily
- Enemeez® (Docusate Sodium mini-enema 283mg) rectal, if no BM in 30 minutes X1, X2, X3 QD

Neurogenic Bowel: Incorporate daily for regimented bowel program

Note: Always remember to check the bowel routine with the patient. Ask if this pattern is unusual, or is it normal for them to have a bowel movement once every 3 days.

Day 2-3

Stimulants: Titrate Sennosides tablets, 2-4 tabs bid up to qid, and Docusate tid up to qid to achieve regular bowel movement.

- Senna 0.5 to 2 grams QD or BID

Note: Administer oral stimulant laxatives, Enemeez® (docusate sodium mini-enema) on Day 3, if ineffective, give suppository, enema whenever a person does not have a bowel movement for 3 days.

Day 3-4


Suppository / Enema: * Enemas that consist of 150 ml of Sodium Phosphate. It may be safely used in short, intermittent courses. Prolonged use of a phosphate preparation can result in hypocalcemia and rectal irritation.

- Glycerin suppository 1 rectal PRN
- Bisacodyl 5-10mg suppository-1 rectally PRN
- Sodium / Potassium phosphate enema-133ml instill rectally PRN

Note: Be sure to assess for bowel obstruction BEFORE initiating aggressive laxative and large volume enema administration. Such therapies are contraindicated in the presence of bowel obstruction, except if obstruction is due to constipated stool.

**Note: Docusate sodium (DSS) can be taken orally or rectally. For these drugs to be most effective, it is essential that a person consumes at least 1 to 2 liters of fluid per day. Glycerin has minimal side effects and is one of the few laxatives that has been recommended as being safe for periodic use with children and infants.*

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Bisacodyl Case Study: Saunders, D.R., Haggitt, R.C., Kimmey, F.E., & Silverstein, F.E. (1990). Morphological consequences of bisacodyl on normal human rectal mucosa: effect of a prostaglandin e1 analog on mucosal injury. *Gastrointestinal Endoscopy*, 36(2), 101-104.

Bowel Product Comparison

Saunders, et.al studied the effects of bisacodyl on normal human rectal mucosa.

- Results showed that bisacodyl (meds/supp) causes **acute injury** to the human rectal mucosa.
- For up to 30 hours after bisacodyl, inflammation persisted as evidenced by neutrophils present in the superficial epithelium and lamina propria.
- These changes mimic a mild, acute colitis.
- Mucosal discharge persisted for up to 3 days after the use of bisacodyl. (described as mucous, butt snot)
- Chronic use of stimulant laxatives may damage the mesenteric plexus and result in colonic dysmotility.



Mini Enemas

Mechanism of the action:

- Functions as a hyperosmotic as well as a stool softening laxative by drawing water into the bowel from surrounding body tissues. Helps soften and loosen the stool.

Administration:

- Rectally, upright on a commode chair/restroom or left side lying.

Therapeutic uses:

- Used with spinal cord injury, stroke, TBI, MS, spina bifida and general constipation, IBS-C, , chronic constipation

Benefits:

- Provides an evacuation in typically 15-20 minutes
- Does **not** produce a mucous discharge(no mucosal injury from chemicals)
- Safe for daily and long-term use
- Reduces episodes of incontinence in half versus bisacodyl suppositories.
- Enemeez® Plus with benzocaine for patients with autonomic dysreflexia or painful moveme



Nursing- the more **EFFECTIVE** the bowel program- the better it is for Nursing!



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- Retention of staff?

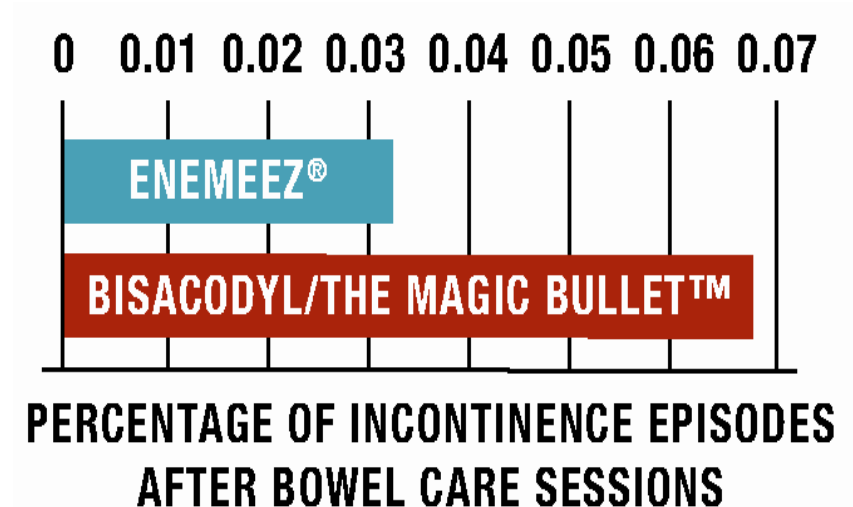
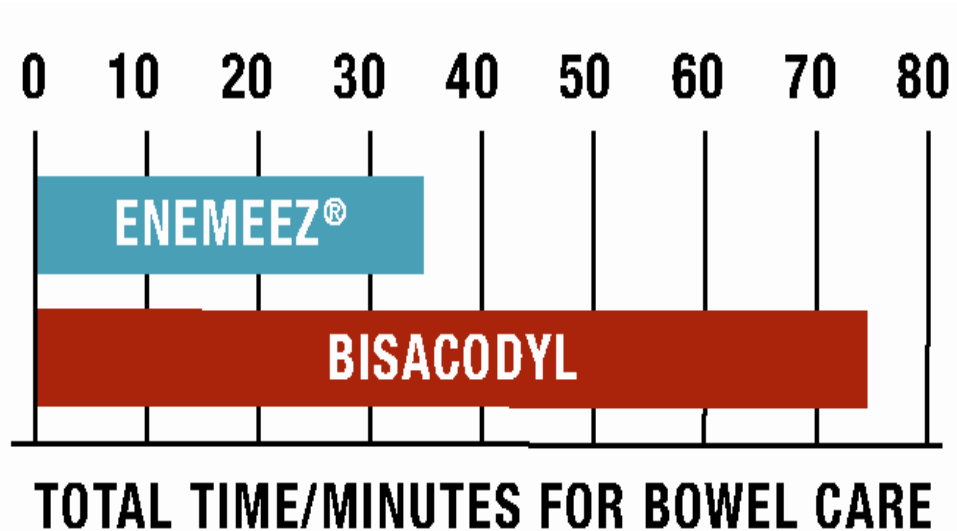


Enemeez vs. Bisacodyl Case Study: Glen House, J, & Stiens, S. (1997). Pharmacologically initiated defecation for persons with spinal cord injury: effectiveness of three agents. *Arch Phys Med Rehabil*, 78, 1062-106

Bowel Product Comparison

Comparison Charts: *Enemeez*® formulation versus Bisacodyl products.

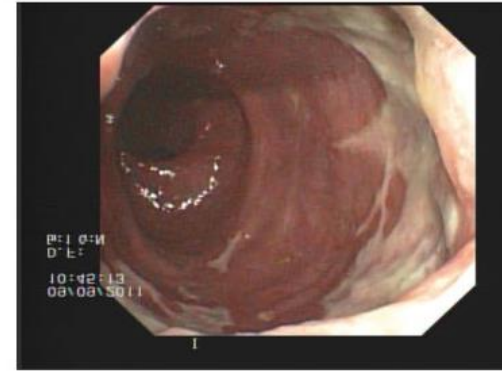
- Episodes of Incontinence
- Total Time for Bowel Care in Minutes.



*Alliance in-house research. Customer survey April 27, 2011, 177 Enemeez® users.

CLEANOUTS

- **Milk of Magnesia**
- **Large dose over a short period of time**
- **Works in 48 hours or less**
- **May cause cramping**
- **Difficult to deliver**



COVID-19, AKA Coronavirus



Researchers in China published a study suggesting that flushing a toilet can create a plume of coronavirus-laden particles, which are flung into the air by the watery vortex inside a toilet bowl.

COVID-19 June 16, 2020 in the journal [*Physics of Fluids*](#).

Recommendations for COVID-19 bowel care best practices



- Any GI symptom(s) should trigger suspicion of COVID-19, and testing should include PCR, fecal/stool specimens and if PCR negative, antibody test for COVID-19.
- ALL Screenings and Assessments should include GI symptoms per CDC screening criteria updated on 4/27/20.
- Patients/caregivers should be educated on the *possible* spread of COVID-19 by oral-fecal route (saliva and feces/stool). Gastroenterologists are recommending best precautions and best practices including:
- No sharing of utensils for eating/drinking. Wash utensils in hot soapy water and scrub for 20 seconds and/or use high temperature dishwasher.
- No reusing toothbrushes without soaking in $\frac{1}{4}$ – $\frac{1}{2}$ strength hydrogen peroxide then rinsing before brushing teeth.
- Provide private bathroom/toilet for patients with GI symptoms and/or + for COVID-19. Wear mask during any bowel care.
- Close toilet lid before flushing to prevent flume
- Disinfect toilet/sink with chlorine-based solutions, if possible, after each bowel movement.
- Use mask/gloves and closure of toilet lid when flushing toilet to prevent aerosolization of viral particles.
- Continue quarantine/precautions for 12-14 days after 2 negative nasopharyngeal swabs until 2 negative feces/stool tests.
- If a clinician is *suspicious* for COVID-19, the CDC recommends immediately contacting the CDC's 24 hr. via the Emergency Operations Center at 740-488-7100 and report MIS-C suspected cases to their state, local, or territorial health departments even if the patient also fulfills all or part of the criteria for Kawasaki disease; AND
- Clinicians who suspect MIS-C should consult promptly with appropriate specialist and test PCR, feces/stool test and antigen/antibody test.

COVID-19- Posters in ALL bathrooms





About Alliance Labs

Driven by a passion to find the right solution for each unique patient challenge

Alliance Labs, LLC, is focused on medicines that change lives, pursues integrity and humanity, and strives to build a team that passionately pursues excellence.

Alliance Labs provides knowledgeable expertise to those facing life-altering illness or injury to reclaim their lives by providing access to the best medical bowel care products available today. In addition, Alliance Labs provides an extensive network of information to assist healthcare providers in their pursuit to provide superior care for their patients and loved ones, as well as aide our patients in their journey to building a more independent life.

Alliance Labs, LLC, is the exclusive distributor of the *Enemeez*® and *DocuSol*® products.



THANK YOU

Questions
Future Webinars
Conferences

See following for more information on laxatives/interventions!

Thank you
cissioloomi@hotmail.com

Bulking Agents

Stool Softeners

Osmotic Agents

Stool Softeners

- Help to keep stools soft for passage
 - *Facilitates addition of fat & water to soften stool*
 - *Add moisture to the stool*
- Can take up to 48 hours to work
- Not a stimulant
- Avoidance of straining

Example

Colace, Docusate sodium

Bulking Agents

- Keeps water in the stool to mechanically distend the colon & promote evacuation
- Prolonged onset of action – Produces an effect in 12 to 72 hours
- Also used in treatment of fi/diarrhea, absorbs free fecal water

Adverse effects:

- Esophageal obstruction
- Intestinal obstruction or impaction

Examples

Psyllium & Methylcellulose

Osmotic Agents

- Increasing the amount of water in the intestines
- Poorly absorbed salts whose osmotic action draws water into the intestinal lumen
- Mechanical cleansing
- May decrease the absorption of oral medications
- Produces an effect in 1-3 days

Adverse effects:

- Substantial loss of water

Examples

Polyethyleneglycol (PEG) 3350, Miralax



Hyperosmolar Agents

Short Term Treatment of Constipation

Examples

- Lactulose
- Sodium phosphate (enema)- Fleets- FDA warning- severe electrolyte imbalance, **caution;**
- Purgative and laxative
- Bowel cleansing
- Contraindicated with impaction & electrolyte imbalance
- Caution with CHF. kidney failure



Colonic Stimulants

- **Promotes peristalsis**
- **Stimulates motility and increases water & electrolytes within the intestinal lumen**

Senna

- Neuroperistaltic stimulation
- Vegetable derivative
- Lowers effects of anticoagulants
- Electrolyte imbalance with excessive use

Bisacodyl

- Direct stimulation with produces peristalsis
- Lowers effects of warfarin and antacids
- Ex: Bisacodyl, exlax, mag citrate , senna

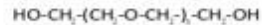
Long Term Use of Large Volume Enemas and Stimulant Laxatives

- **Last resort or Rescue**
- **Stimulant laxatives** such as bisacodyl, Exlax, cascara, senna, and magnesium citrate are not recommended for use as a regular part of a bowel program and negatively affect the nerves of the colon. ¹
 - May cause severe diarrhea with resulting dehydration, and loss of electrolytes.
 - Likely to cause intestinal cramping.
 - Chronic use may damage the colon and worsen constipation.
- Large volume enemas are only meant for occasional use. Frequent use of enemas can cause disturbances of the fluids and electrolytes in the body. ²
- Any full-size enema and **stimulant** laxatives and suppositories are too irritating to the bowel and can cause autonomic dysreflexia. ²

PEG/MiraLAX

Miralax

Polyethylene Glycol



PEG are the polymers of ethylene oxide with a molecular mass between 300 to 20,000 Dalton

PEG 3350 and 4000 are the mainly used as laxatives. Most of the marketed preparations world wide have PEG 3350

Biological Properties of PEG +E

- ✓ High water binding capacity (dose-dependent)
- ✓ Allows a controlled water transport into the colon
- ✓ No fermentation or relevant absorption in the colon (inert macromolecule)

Other Benefits

- ✓ Iso-osmotic by nature
- ✓ Negligible net gain/loss of electrolytes

Works in harmony with the body's own processes to increase stool volume and assist with comfortable, healthy bowel movements^{1,2}

Works in 4 Ways



peristeen



Company rep needs to train!



ACE PROCEDURE

- **A tube like structure is created from the appendix**
- **The tube goes from the ascending colon to the right lower abdominal wall**
- **Enemas every three days empty the colon completely**