SESLHD GUIDELINE COVER SHEET

NAME OF DOCUMENT	Bowel Management
TYPE OF DOCUMENT	GUIDELINE
DOCUMENT NUMBER	SESLHDGL/098
DATE OF PUBLICATION	September 2022
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 4 – Medication Safety Standard 5 – Comprehensive Care NSW Health PD2013_043 - Medication Handling in NSW Public Health Facilities NSW Health PD2012_006 - Safe Administration of Liquid Medicines by Routes other than Injection SESLHD Nurse Initiated Protocols
REVIEW DATE	September 2025
FORMER REFERENCE(S)	N/A
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Medicine
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FUNCTIONAL GROUP(S)	Medicine
KEY TERMS	Constipation, Digital Rectal Examination (DRE), Enema Administration
SUMMARY	To provide guidance and advise on the procedures for the successful assessment, management and prevention of constipation in adult inpatients to ensure safe and effective patient management.

SESLHD GUIDELINE COVER SHEET

Health
South Eastern Sydney
Local Health District

Bowel Management

Section 1 - Background

Successful management of constipation and altered bowel habits depends on the assessment and identification of the underlying cause and/or other contributory factors.

Prevention of constipation is imperative and a direct nursing responsibility.

Early and accurate assessment, followed by preventative measures can eliminate the need for more invasive treatments.

All information on bowel assessment and management should be clearly and consistently documented on a daily basis. This information should be handed over across all shifts and on inter-ward and inter-hospital transfers.

RESOURCE PERSONNEL

The ward based Clinical Nurse Specialists (CNS) and Clinical Nurse Educators (CNE) should be contacted to assist with bowel management in the first instance

Other Specialist or Clinical Nurse Consultant (CNC) teams and allied health professionals may be contacted for further consultation during business hours.

The Sutherland Hospital	
Ward / Unit Clinical Nurse Educators / Specialist	Palliative Care
Admitting Medical Team	Continence
	Aged Care
St George Hospital	
Ward / Unit Clinical Nurse Educators/ Specialist	Palliative Care
Admitting Medical Team	Continence
	Aged Care
	Anorectal
Prince of Wales Hospital	
Ward / Unit Clinical Nurse Educators/ Specialist	Palliative Care
Admitting Medical Team	Continence
	Aged Care
	Anorectal

Section 2 - Principles

EXCLUSIONS

Patients with the following conditions will NOT have Digital Rectal Examination (DRE) or administration of per rectum aperients before consultation with the treating medical team.

- Patients requiring serial abdominal assessment post trauma
- Existing bowel pathology e.g.: inflammatory bowel disease, Crohn's disease, ulcerative colitis, toxic megacolon
- Following bowel or rectal surgery or patients with rectal bleeding:
- Patients with ileostomy or jejunostomy
- Patients unable to tolerate enteral feeding/oral diet:
- Patients with raised intracranial pressure - consult the treating intensivist or neurosurgeon before performing PR examination or aperient administration
- Neutropenic patients
- Patients with a Platelet count of less than 30 (Confirmation of platelet count would need to be obtained from Haematology)
-Spinal injury patients will be managed according to local policy and ACI regime

EXPECTED OUTCOMES OF A PROGRAM TO PREVENT/MANAGE CONSTIPATION

- Patient establishes a pattern of elimination consistent with his or her norm and is comfortable in relation to elimination
- Nursing strategies are implemented to modify or restore to normal the patient's pattern of elimination
- Nursing strategies are evaluated daily, altered according to the patient's elimination pattern and level of comfort and documented in the clinical notes/bedside handover tool.

AIMS OF A PROGRAM TO PREVENT/MANAGE CONSTIPATION

- Achieve regular effective and efficient emptying (evacuation) of the colon avoiding intermittent treatment for faecal overloading or impaction
- Prevent constipation, faecal impaction and resultant faecal incontinence
- Effectively treat impaction and overload and return bowel function to normal.

PRINCIPLES OF EFFECTIVE PREVENTION/MANAGEMENT OF CONSTIPATION

- Patients using bulking agents must be able to tolerate the increased fluid intake required for use of these agents, otherwise they are at risk of obstruction or impaction.
- Patients using bulking agents must have normal colonic transit i.e. **NO** underlying neurogenic conditions such as Parkinson's disease, slow transit constipation, MS, motor neurone disease.
- When laxatives are required select a recommended laxative (Section 6) and avoid using those which must be used with caution (Section 7).

- All patients with chronic bowel management problems should be referred to a specialist nurse for assessment.
- If bowels not open for 3 days and recommended interventions have been implemented, the patient requires full assessment for possible faecal impaction/overload/obstruction, including medical review and possible abdominal x-ray +/- DRE.

RISK FACTORS FOR CONSTIPATION

- Immobility
- Spinal injury
- Lower back injury / surgery particularly S1 – S4
- Neurological diseases e.g. Parkinson's disease, MS, motor neurone disease and dementia.
- Inadequate dietary intake and low fibre diets
- Reduced fluid intake/dehydration
- Modified diets such as puree and thickened fluids
- Cognitive/psychiatric deficits
- Communication deficits including aphasia and NESB
- Pain e.g. Anal fissures or haemorrhoids, recent surgery
- Patients who have regular laxatives, now ceased due to hospitalisation
- Medications eg: Opioids, drugs with anticholinergic effects, antidepressants, aluminium-containing antacids, verapamil and calcium or iron supplements.
- Physiological and psychological barriers such as lack of privacy, bedpans shared bathroom.

Section 3 - Definitions

Definition: **Constipation**

- Constipation refers to difficulty, straining and passing of hard dry stools and infrequent bowel movements over a period of time. It is a highly subjective symptom with normal bowel habits varying between individuals.
- Defining constipation must involve measureable objective symptoms including frequency of defecation and stool characteristics, as well as the patient's perception of constipation relating to ease of defecation and associated level of discomfort.
- Definition by National Institute of Diabetes and Digestive and Kidney Diseases is bowel movement less than 3 times a week, that is hard, dry and/or lumpy and the evacuation is difficult.
- Although constipation is exacerbated by **opioids** and anticholinergic drugs, the cause of constipation is usually multifactorial.
- The consequences of unmanaged constipation include abdominal pain, bloating, nausea, overflow incontinence, tenesmus, faecal impaction, urinary retention and occasionally bowel obstruction and colonic perforation; all of which can profoundly affect the quality of life

Definition: **Faecal Loading**

The inability to evacuate large, hard inspissated compacted stool or bezoar lodged in the lower GI tract.

Definition: **Faecal Impaction**

- A solid immobile bulk of faeces that develops in the rectum as a result of chronic constipation.
- Faecal impaction must be clinically diagnosed.
- Abdominal X-ray ***may*** be required to determine extent of impaction. (*A plain abdominal X-ray is of limited utility in diagnosis of constipation, and is mainly used to exclude bowel obstruction*).

Definition: **Collapsed Rectum**

- The rectal wall should be easily felt collapsed around the examining finger.
- This usually indicates a functioning bowel

Definition: **Ballooned Rectum**

- Rectum feels dilated on examination.
- A ballooned (dilated) rectum is indicative of gross constipation
- An empty ballooned rectum may indicate faeces high up in the bowel, or it may be a sign of bowel obstruction
- Consider abdominal X-Ray.

Definition: **Laxatives (Aperients)**

- Medication commonly used to treat constipation and classified by the mode of action into categories of bulking agents, stimulant laxatives, faecal softeners and osmotic laxatives.

Definition: **Enema**

- An enema is the introduction of fluid through the anus into the rectum and colon.
- A retention enema is fluid that is introduced into the rectum to be retained.

Definition: **Digital Rectal Examination (DRE)**

- A DRE is the examination of the rectum with a gloved and lubricated finger for the purpose of:
  - Establishing the presence, amount and consistency of faecal matter in the bowel.
  - Assessing the need for rectal medication or digital removal of faeces in extreme cased of faecal impaction.
  - Gauging anal sphincter function and tone and rectal sensation.

Definition: ***Manual Disimpaction***

- Manual disimpaction is the digital removal of stool from the rectum using a gloved and lubricated finger. Refer to Appendix

Section 4 - Responsibilities

Nurse /Midwifery Unit Managers (NUM/MUM) / Department Managers are responsible for:

- Ensuring compliance with this guideline in their unit department.

Medical Officers are responsible for:

- Undertaking regular review of patients based on clinical assessment and when alerted to an issue by nursing staff.
- Documentation of clinical assessment findings and a clear management plan
- The prescribing of appropriate bowel medications and regular review of the response to those medications.

Registered Nurses (RN) / Midwives (RM) are responsible for:

- Daily assessment and evaluation of the patients' bowel habits to identify altered bowel habits according to the patient elimination pattern and level of comfort.
- Documenting findings as per Section 8 in the patients eMR record & eMR bowel chart
- Implementing strategies to modify or restore the patients' normal pattern on elimination, including the administration of nurse initiated and prescribed medication as appropriate.
- Escalate failure to respond to interventions to the treating team and N/MUM.

Enrolled Nurses (EN) are responsible for:

- Daily assessment and evaluation of the patients' bowel habits to identify altered bowel habits according to the patient elimination pattern and level of comfort.
- Documenting findings as per Section 8 and report findings to the Registered Nurse
- Implement strategies to modify or restore the patients' normal pattern on elimination, including the administration of nurse initiated and prescribed medication within scope of practice.

NOTE: Only ENs without notation may administer medications as per SESLHDPD/160 - Medication: Administration by Enrolled Nurses and SESLHD Nurse Initiated Protocols.

Assistants in Nursing (AIN) are responsible for:

- Daily assessment and evaluation of the patients' bowel habits to identify altered bowel habits according to the patient elimination pattern and level of comfort.
- Documenting findings as per Section 8 and report findings to the Registered Nurse
- Liaise with Medical and Nursing/Midwifery staff regarding nutritional management.
- Document assessment and intervention in the eMR medical record.

Section 5 – Assessment

ASSESSMENT AND DOCUMENTATION ON ADMISSION TO HOSPITAL OR COMMUNITY SERVICE – ALL PATIENTS

- On admission initial assessment is completed in the Elimination Section on Adult Admission Assessment (AAA). It is important to gather additional information if there are concerns that the patient is at risk of altered elimination. Appropriate assessment should include interviewing the patient/significant other to obtain:
  - Previous bowel history
  - Usual patterns/continence status
  - Existing bowel status
  - Laxative use
- Identify known risk factors (Refer to Section 2 page 5) for constipation and resultant overflow/faecal incontinence
- DAILY documentation is the minimum standard of bowel status
- Documentation on the eMR Bowel chart is required for all patients – especially those at risk of constipation and consider need for a fluid balance chart & fluid balance summary chart
- Appropriate assessment strategies are supported by documentation prior to implementing prevention and/or treatment of constipation or faecal impaction
- Evaluation and outcomes related to assessment and management regime must be included in the clinical notes where a problem or potential problem exists
- Documentation - refer to section

PHYSICAL EXAMINATION

Undertake an abdominal examination if the patient:

- Has failed to pass stool (as per Bristol Stool Form Scale on the Bowel Management Chart in eMR after 3 consecutive days
- Is confused and unable to give a history (where family, carer or facility cannot provide the information)
- Abdominal Assessment - inspect, auscultate, percuss and palpate all abdominal quadrants See Appendix A

NOTE:

- Physical examination may include either an Abdominal X-Ray and/or DRE (refer to Appendix B) in consultation with the medical team.

CONSTIPATION MANAGEMENT

Prevention and Treatment for All Patients

- Conduct assessment and physical examination if indicated
- Document findings in the patients eMR record & eMR bowel chart
- Monitor and document bowel status daily as a minimum
- Ensure the patient's regular laxatives (if applicable) are prescribed and administered
- Implement recommendations according to risk status

Low Risk of Constipation

- *Patients with minimal or no risk factors for constipation as per Section 2 Risk Factors*
  - If bowels not opened for 2 days commence a low dose of oral aperients
    - Recommended agents are (also refer to Section 7)
      - Macrogol 3350 (Movicol 1-3 sachets daily, Osmolax 2 -6 scoops daily), OR
      - Normacol 2 teaspoons nocte

- *Patients with Risk Factors*
  - If bowels not opened for 2 days discuss management plan with the patient
  - Consult a ward CNS/CNE then treating medical team for advice (for additional resource personnel refer to Section 1)
  - Suggest DRE and manage as per flow chart "Interventions related to DRE findings" – refer to Appendix E
  - If patient unwilling to consent to DRE, continue oral aperients as above
  - If bowels not opened for 3 days patient requires a DRE and further management as per flow chart Appendix E
  - Reassess risk and titrate aperients daily according to bowel action.

High Risk of Constipation

- *Patients at moderate to high risk of constipation (refer to Section 2 page 5)*
  - If no regular aperients taken at home, or aperients are ineffective, commence aperient according to individual patient assessment and risk factors (refer to 4.13).
  - If bowels not opened for 2 days, discuss management plan with patient
  - Perform DRE and manage as per flow chart Appendix E
  - Reassess risk and titrate aperients daily according to bowel action.

Opioids

- *Patients receiving opioid medications are at particularly high risk of constipation.*
  - Docusate & Senna are available in combination (Coloxyl & Senna ®) and are the aperients of choice as they counteract the effect of morphine on the gut with dual stimulant and softener action
  - Recommended dose 2 tablets nocte
  - If not effective –refer to the treating medical team

DISCHARGE PLANNING FOR PREVENTION/MANAGEMENT OF CONSTIPATION

For specific advice on discharge management refer to the relevant medical recommendations as per patients discharge summary.

- **Aims and expected outcomes**
  - All patients to be discharged with an established elimination pattern OR appropriate bowel management strategies are identified and patient education attended pre discharge
  - Return to normal premorbid bowel habit on discharge
  - Management strategies for alterations to elimination pattern are instigated.
  - Review patient history of bowel activity during admission
  - Review patient's long-term history
  - Identify if intervention required post discharge
  - Identify action required and timeframe
  - Consider follow-up with GP if further management is required.

- **Discharge management and follow-up**
  - Establish bowel pattern both premorbid and current.
  - Identify possible causes of altered elimination pattern e.g. poor oral intake, fluid restriction, lack of exercise, medications.
  - If dietary causes identified refer to dietician as inpatient or outpatient.
  - Consider follow-up with GP if further management is required.

Section 6 – Laxatives (Recommended)

Refer to SESLHD Nurse Initiated Protocols

BULKING AGENTS	TYPE	ACTION	COMMENTS
Psyllium (Metamucil) Wheat Dextrin (Benefiber) Methycellulose (Normafibe)	Powder Granules	Bulking agent / fibre supplement	Increases the faecal mass which stimulates peristalsis and produces bulkier, softer stools. Needs adequate fluid intake
Sterculia & Methycellulose (Normacol Plus)	Granules	Bulking agent with a laxative	Mild stimulant laxative combined with the fibre that increases the faecal mass which stimulates peristalsis and produces bulkier, softer stools. Needs adequate fluid intake
SOFTENER	**TYPE**	**ACTION**	**COMMENTS**
Sodium Docusate (Coloxyl)	Drops Tablets	Faecal softener	Suitable for all patients as a first line treatment for chronic constipation
Olive oil	Liquid	Faecal softener	Softener only
OSMOTICS	**TYPE**	**ACTION**	**COMMENTS**
Macrogol 3350– see also 4.17 (Movicol, Osmolax)	Powder	Delivers water to the colon, softens stool and increases peristalsis. There is no net loss of sodium, potassium and water.	Patients need to be able to tolerate drinking 125 mL water or juice per sachet. Can have up to 8 sachets per day for faecal impaction. Not suitable for patients on modified diets.
Lactulose (duphalac, sorbital)	Syrup	Water is drawn into the bowel, increasing the fluid volume softening the stool and increasing peristalsis	Requires a high fluid intake. Can cause fluid and electrolyte imbalances, diarrhoea and abdominal cramps. Is not suitable for the elderly in large doses. Is suitable for diabetics.

STIMULANTS	TYPE	ACTION	COMMENTS
Bisacodyl (Dulcolax)	Tablets	Increases pressure waves in colon and stimulates emptying.	Can cause cramps and bloating.
Docusate & Senna (Coloxyl & Senna ®)	Tablets	Faecal softener and peristaltic stimulant	Maintain adequate water intake.
Sodium picasulphate (Dulcolax drops)	Drops	Stimulates peristalsis and promotes accumulation of water into the bowel	Requires a high fluid intake. Can cause fluid and electrolyte imbalances.
RECTAL LAXATIVES	**TYPE**	**ACTION**	**COMMENTS**
Glycerin suppository	Suppository	Glycerine softens stools by osmosis and is also a lubricant	Suitable for all age groups as first line management Should be inserted rectally into the stool.
Bisacodyl suppository	Suppository	Stimulant increases peristalsis	Suitable to be given in combination with glycerin suppository. Should be placed against the rectal wall as it is absorbed through the rectal mucosa. May cause cramping.

Section 7 – Laxatives (Other)

THESE LAXATIVES MUST BE PRESCRIBED BY A MEDICAL OFFICER			
Fleet Enema (Sodium Phosphate)	Enema	Promotes evacuation of the bowel by increasing bulk volume and water content of stools	A DRE must be performed prior to insertion to ensure no contraindications for administering the fleet enema. ****At POWH the initial DRE must be performed by a medical officer**** Use with caution in patients with impaired renal function, heart disease or pre-existing electrolyte disturbances. Also patients on calcium channel blockers, diuretics or other medications that may affect electrolyte levels. Repeated dosage may result in hyperphosphataemia, hypernatraemia and acidosis may occur. Additional fluids by mouth are recommended where appropriate. An irrigation / enema cone must be used for the administration of a Fleet enema at POW (refer to appendix C). Administering the fleet enema without caution may cause adverse outcomes including bowel perforation. If after the enema solution is administered there is no return of liquid, contact a doctor immediately as dehydration could occur. **It is not necessary to empty the bottle completely and do not force all contents in. The outcome of the examination needs to be documented on eMR medical progress note clearly.
Microlax Enema	Enema	Acts to increase intestinal water secretion and stimulate peristalsis. Each 5 mL enema contains sodium citrate 450 mg, sodium lauryl sulfoacetate 45 mg, sorbitol 3.125 g.	A DRE must be performed prior to insertion. Gently insert the lubricated enema tip into the rectum. If tip does not insert freely or patient complains of pain, stop immediately. Seek medical advice before continuing. Advise patient to remain in position and hold contents of enema in rectum for at least 10 minutes if possible.

Olive Oil Enema	Oil	Rectal lubricant	A DRE must be performed prior to insertion. Olive oil (100-150mL) is retained in the rectum overnight to soften hard or impacted faeces to allow easier evacuation. Do not expect immediate results. The enema may need to be repeated daily before evacuation is achieved. Efficacy depends on the patient's ability to retain the oil. This is usually administered in conjunction with oral aperients or followed by stimulant suppository 12 hours after oil administration.

DOSAGE OPTIONS FOR MACROGOL 3350 (Movicol, Osmolax)
INCLUDING ENEMA RECOMMENDATIONS FOR FAECAL IMPACTION.

- **Dosage for prevention of constipation**

Dissolve the contents of 1 sachet of Movicol in 125 mL of water and have the patient drink the mixture.

a) Dosage for Constipated Patients

- Commence with 13.8 g 1 sachet or 2 scoops per day.
- Opiate induced constipation may need a higher dose.
- Adjust the dose upwards by 1 sachet per day up to a maximum of 4 sachets per day until a bowel movement is achieved.
- Once bowels are moving, use the Bristol Stool scale to titrate Movicol dose to achieve a Type 3 or Type 4 stool.

b) Dosage for Faecal impaction (Option 1, 2 OR 3 as per treating team)

- Faecal impaction must be clinically diagnosed by abdominal imaging
- Abdomen X-ray may be necessary to determine the amount of impaction +/- a DRE
- Option 1: Administer fleet or olive oil enema to clear the distal bowel
- Option 2: Dissolve one sachet of sodium pica sulphate (PicoPrep) into 250 mL water and take orally in combination with movicol, low dose
- Repeat after 2 hours if impaction severe.
- Option 3: Movicol - A Stat dose of 8 sachets dissolved in 1 litre of water and consumed within 6 hours per day for a maximum of 3 days.
- Encourage oral fluids and ambulation if patient is able. If oral fluids are limited or patient on a fluid restriction, suggest IV hydration.

c) Administration via an Enteral Feeding Device

- DO NOT use intravenous infusion devices for administering medications or fluid via the enteral route
- Administer immediately after preparation by a manual bolus syringe method and flush with water following administration before the residue thickens in the tube
- For administration via a jejunostomy administer in 50 mL increments
- Ensure the patient has been referred to a dietician so that feeding regimen can be reviewed and changed if clinically indicated
- Check appropriate method via MIMMs for crushable oral agents that can be administered via an enteral device in consultation with pharmacy.

Section 8 - Documentation

DOCUMENTATION OF ADMISSION ASSESSMENT AND PHYSICAL EXAMINATION

Following admission assessment and physical examination document the following patients' eMR record.

Current history

- Normal activities to maintain bowel function (e.g. what works for the patient)
- Any history of bowel surgery / conditions
- Changes in bowel habits
- Changes in amount of flatus passed
- Feeling of incomplete emptying
- Straining and/or inability to pass stool
- Type of stool, as per the Bristol Stool Form Chart
- If recent illness what was their normal bowel pattern prior to illness
- Identify aperient use – type, frequency and length of time used
- Individual preferences and special toileting needs e.g. raised toilet seat, foot stool etc
- Any pain and or blood with defaecation
- Presence of faecal incontinence
- Risk factors for constipation (Section 2 page 5).

Findings of abdominal assessment

- Presence/absence of abdominal distention or bloating
- Presence/absence of bowel sounds.

Findings of Digital Rectal Examination (DRE) if applicable – refer to Appendix E

Section 9 - References

1. Alarcon de la Lastra C, Barranco MD, Motilva V, Hurerias JM. (2001). Mediterranean Diet and Health: biological importance of olive oil. Current Pharmaceutical Design; (10) 933-950
2. Calvary Health Care Sydney Policy Number: 35 - : Bowel Management : Palliative Care
3. Candy B, Jones L, Larkin PJ, Vickerstaff V, Tookman A, Stone P (2015), Laxatives for the management of constipation in people receiving palliative care. The Cochrane Database of Systematic Reviews.
4. Coggrave M, Norton C, Cody JD (2014), Management of faecal incontinence and constipation in adults with central neurological diseases. The Cochrane Database of Systematic Reviews.
5. De Schryver,AM, Keulemans YC,Peters HP, Akkermans LM, Smout AJ, De Vries WR, van Berge-Henegouwen GP. (2005). Effects of regular physical exercise on defaecation pattern. Scand J Gastroentererol.
6. Jackson R, Cheng P, Moreman S, Davey, N & Owen, L (2016), "The constipation conundrum": Improving recognition of constipation on a gastroenterology ward. BMJ Quality Improvement Reports.
7. Kumar, L, Barker, C & Emmanuel, A (2014), Opioid-induced constipation: pathophysiology, clinical consequences and management. Gastroenterology Research and Practice, vol 2014
8. Lee-Robichaud H, Thomas K, Morgan J, Nelson RL (2010), Lactulose versus Polyethylene Glycol for Chronic Constipation. The Cochrane Database of Systematic Reviews
9. Lizarondo, L (2018), Constipation in Hospitalized Patients: Management. The Joanna Briggs Institute EBP Database.
10. Long Khanh-Dao Le, B.Pharm, (2018). Constipation Management (Older Person). The Joanna Briggs Institute EBP Database.
11. O'Laughlen, M 2009, Making sense of abdominal assessment, *Nursing Made Incredibly Easy*, vol. 7, no 5, pp. 15-19, Lippincott Williams & Wilkins, Inc.
12. *Peate, I. (2003). Nursing role in the management of constipation: use of laxatives.* British Journal of Nursing *12 (19) pp 1130 -36.*
13. *Powell, M., Rigby, D. (2000). Management of bowel dysfunction and evacuation difficulties. Nursing Standard 14 (4) pp 47-51.*
14. Royal College of Nursing (2019) Bowel Care Management of lower bowel dysfunction including Digital Rectal Examination and Digital Removal of Faeces. London. RCN
15. Richmond, J. (2003). Prevention of Constipation through risk management. Nursing Standard, 17(16), 39-48.
16. Cherny N, Fallon M, Kaasa S, Portenoy R & Currow D (eds) 2015 Oxford Textbook of Palliative Medicine (5th Ed), Oxford University Press, Oxford. pp 675-685.
17. Wisten, A & Messner, T. (2005) Fruit and Fibre in the Prevention of Constipation. Scandinavian Journal of Caring Sciences Vol 19 p71.

Revision and Approval History

Date	Revision no:	Author and approval
January 2022	DRAFT	Initial draft. Published on Draft for Comments page.
June 2022	DRAFT	Final version approved by Executive Sponsor. To be tabled at Quality Use of Medicines Committee and Clinical and Quality Council.
July 2022	DRAFT	Endorsed by the Quality Use of Medicines Committee with minor amendments.
September 2022	1	Approved at the Clinical and Quality Council meeting.

Appendix A: Abdominal Assessment

Performing an abdominal assessment, prior to treating a patient for constipation, will help you detect health problems in your patients earlier and prevent further complications from developing.

Have the patient lying flat with a single pillow under their head and the abdomen sufficiently exposed prior to performing examination, otherwise risk activation of abdominal muscles and distortion of anatomy which means examination findings may be unreliable.

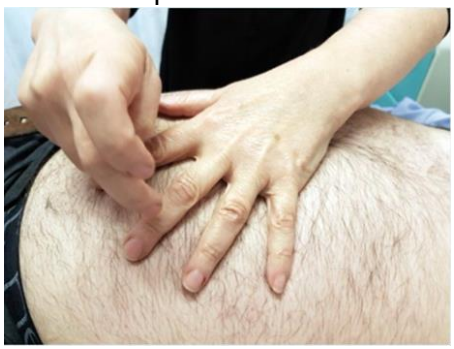
Inspection
Visually inspect the abdomen for obvious abnormalities e.g. swelling, bruising, ascites, asymmetry, and localised enlargement. A localised enlargement may indicate a hernia, tumour, cysts, bowel obstruction or enlargement of abdominal organs which can contribute to constipation. A distended abdomen may also a sign of faecal overload. Any abnormalities need to be reported to the medical team prior to proceeding with any nurse initiated treatment.

Auscultation
Normal bowel sounds are gurgling sounds (usually occurring between 5 and 35 times per minute) that can be heard with the diaphragm of a stethoscope. Ileus is a condition in which there is a lack of intestinal activity. Decreased sounds, such as no sounds for 1 minute, are a sign of decreased gut activity. Bowel sounds may be noticeably decreased after abdominal surgery, abdominal infection, or injury. Absent sounds (no sounds for 5 minutes) are a warning sign of a potential intestinal obstruction, intestinal perforation, ileus, intestinal ischemia or infarction. A decrease or absence of bowel sounds should be reported to the medical team immediately. Reduced (hypoactive) bowel sounds include a reduction in the loudness, tone, or regularity of the sounds. They are a sign that intestinal activity has slowed. Hypoactive bowel sounds are normal during sleep. They also occur normally for a short time after the use of certain medicines and after abdominal surgery. Decreased or absent bowel sounds often indicate constipation. Increased (hyperactive) bowel sounds can sometimes be heard even without a stethoscope. Hyperactive bowel sounds mean there is an increase in intestinal activity. This may happen with diarrhoea or after eating.

Percussion
With your patient lying supine, percuss all four quadrants of the abdomen using proper technique as follows - hyperextend the middle finger of your non dominant hand and place this finger firmly against your patient's abdomen. With the end (not the pad) of your dominant middle finger, use a quick flick of your wrist to strike the finger on the abdomen. Categorise what you hear as tympanitic or dull.

- **Tympany** is a high pitch (tinkling) sound that is usually present in most of the abdomen caused by air in the bowel, this is associated with a bowel obstruction

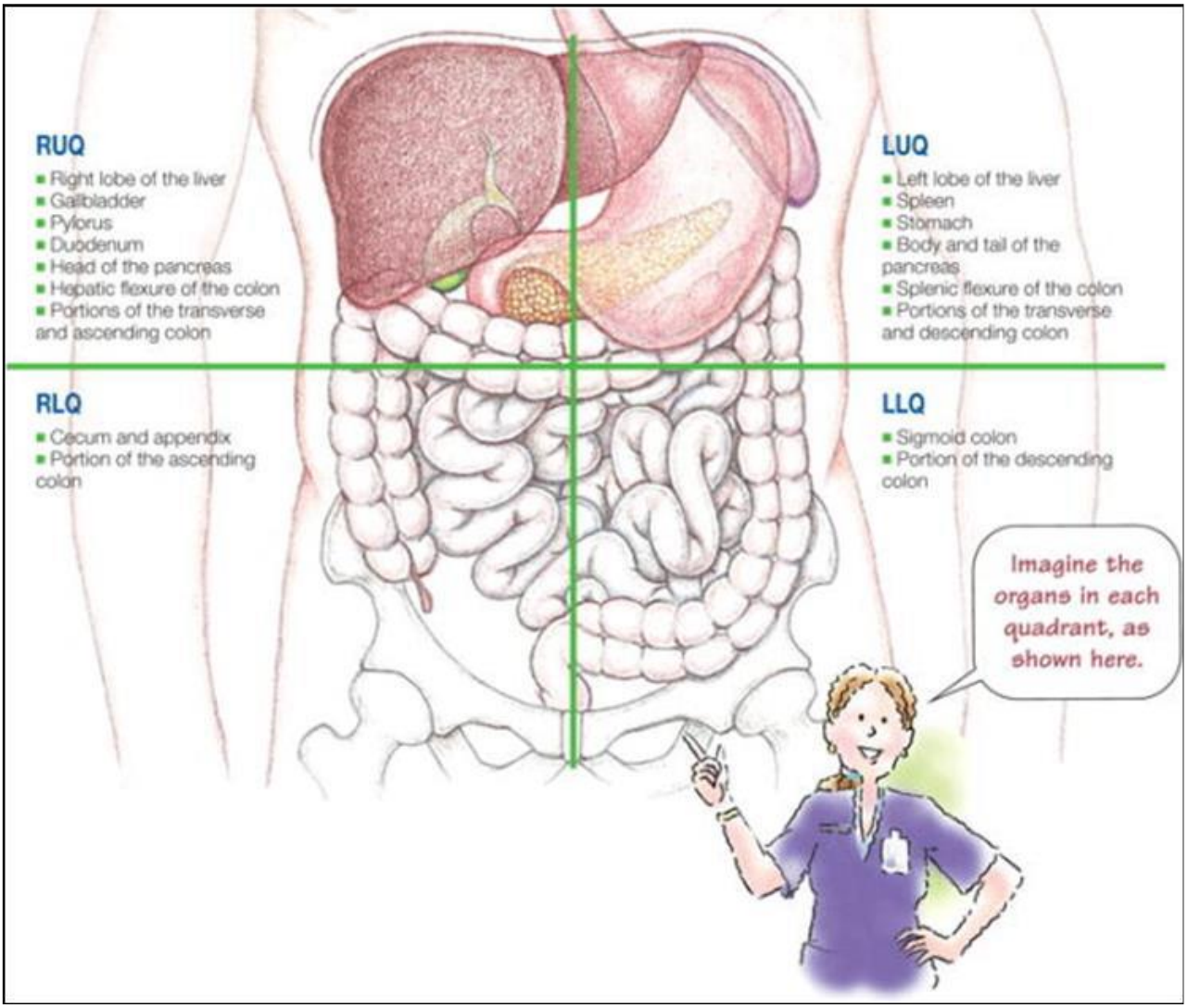
- **Dullness** is a flat sound without echoes; that is detected over solid masses such as organs but also in ascites. An unusual dullness may be a clue to an underlying abdominal mass and should be reported to the medical team.



Technique for Percussion
With your patient in supine position, percuss all four quadrants of the abdomen using proper technique as follows - hyperextend the middle finger of your non dominant hand and place this finger firmly against your patient's abdomen.

Palpation

To palpate put the fingers of one hand together and depress skin ½ the depth of the abdomen with your fingertips and make gentle rotating movements. The abdomen should be soft and non-tender. Palpate all four quadrants and take note of masses and areas of resistance and tenderness. Any abnormalities and areas of tenderness should be reported to the medical team.



References

- O'Laughlen, M 2009, Making sense of abdominal assessment, *Nursing Made Incredibly Easy*, vol. 7, no 5, pp. 15-19, Lippincott Williams & Wilkins, Inc.
- https://www.nursingtimes.net/clinical-archive/long-term-conditions/management-of-ascites-in-patients-with-liver-disease-18-09-2018/

Appendix B: Digital Rectal Examination (DRE)

DRE examination must be performed by a MO, RN or EN with another member of staff present if indicated. The patient's dignity and privacy are maintained at all times; including considering the gender of the nurse performing the DRE in the context of the patient's gender, expressed preference and cultural/religious background.

1. Limitations for Practice

- RN or EN must receive education in performing DRE.
- An RN or EN who has not received education should:
  - Read the procedure in this appendix AND
  - Arrange education by consulting with an RN with expertise in DRE or one of the resource personnel listed on page 1.
- EN must always consult an RN prior to performing DRE to determine appropriateness of the procedure and to formulate a treatment plan. Following consultation, DRE is delegated by an RN to the EN if the procedure is indicated.

2. Indications for Digital Rectal Examination

- To assess anal tone, sphincter function and sensation, characteristics of rectal wall (dilated or collapsed)
- To assess if faecal matter is present, its amount and consistency
- To assess the need for aperients – particularly in patients who have had no bowel action for ≥ 3 days or in whom faecal impaction is suspected.

3. Clinical history to be obtained prior to digital rectal examination

- Determine whether there are contraindications to performing a DRE (see points 3 and 4)
- Precautions refer to conditions which are not necessarily contraindications but special care must be taken due to increased risk of rectal trauma in patients with these conditions - medical consultation may be required prior to attending a DRE in these patients
- The decision to perform a DRE on patients with conditions listed under precautions should be made in consultation with the treating medical team and documented in the clinical notes by the treating MO prior to commencing a DRE

4. Precautions

A clinical history must be obtained prior to proceeding with DRE refer to Section 2 Principles

- Radiotherapy to the pelvic area within the last 6 weeks – consult the Cancer Care Centre nursing staff or treating Radiation Oncologist prior to performing DRE
- Recent cytotoxic therapy where the patient may potentially be neutropenic
- Rectal prolapse (depending on degree and any accompanying ulceration) – consult a member of the treating medical team
- Recent rectal surgery including anterior resection, rectocele repair, rectopexy – consult a member of the treating medical team
- Recent perineal or anal sphincter repair or injury e.g.: post vaginal birth – consult the treating medical officer
- Known history of sexual or physical abuse – consult with the treating medical team or mental health professional

- Ensure no known allergies to any of the equipment (i.e.: latex) or anticipated medication.

Contraindications

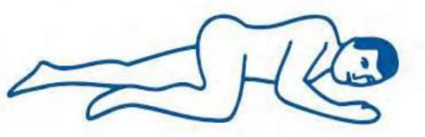
- Patient does not consent
- Active inflammatory bowel disease including Crohn's disease, ulcerative colitis, diverticulitis
- Rectal excision, anterior resection or ileal pouch surgery within the last 14 weeks
- Trauma to the anal or rectal area
- Obvious per rectal (PR) bleeding
- Rectal or anal pain of unknown cause.
- Anal or rectal lesion/mass
- Tissue fragility
- Spinal injury at risk of autonomic dysreflexia
- Foreign body in rectum or anus
- Imminent terminal event in palliative patient where the procedure will be of questionable value but potentially painful or distressing.
- Haematological disorders i.e. decreased platelets of less than 30.

Preparation for procedure

- Inform and educate the patient about the procedure and ensure patient consents to the procedure
- Explain the expected outcome and advise that the urge to defaecate following administration of aperients may occur with minimal warning.
- Collect equipment
  - Blue sheet x 2
  - Personal protective equipment (PPE) 2 - 3 pairs gloves, disposable apron, facial protection
  - Lubricant – 2 sachets
  - Rectal medication as ordered on medication chart or according to Nurse Initiated Medications ClBR
- Provide an environment to maximise privacy
- At any time during the procedure if the patient experiences discomfort or becomes agitated:
  - Ask the patient if they wish to continue
  - If the patient consents to continue the nurse may proceed
  - If the procedure is terminated notify/consult with the treating medical team
  - Document a complete description of the procedure (including if the procedure is terminated) including a description of the patient's reported pain using a pain scale appropriate for the patient

Procedure

- Perform hand hygiene
- Don PPE
- Position patient left lateral position with knees to chest (as per picture)
- Put protective blue sheets on bed linen
- Observe perianal area for abnormalities.



If the following are detected the nurse should proceed with caution:

* *Anal lesions*	* *Faecal matter*
* *Haemorrhoids*	* *Gaping anus*
* *Anal skin tags*	* *Abnormal perianal skin*
* *Wounds*	* *Infestations i.e.: parasites*

PROCEDURE NOTE

The double glove method may be used by an RN where the first pair of gloves is removed after DRE and the 2nd clean pair used to administer aperients **if indicated.**

An EN who has passed competency assessment may use this method providing the EN has consulted with the RN regarding what findings would indicate the administration of aperients.

- Identify anal opening
- Lubricate index finger and outside of anus
- Wipe finger across anus to provoke anal reflex
- Gently insert index finger with the palm facing down
- During insertion rotate finger through 180 degrees, feeling the circumference of the anal canal
- Feel to the top of the anal canal and into the base of the rectum. Note any faeces type and consistency and the presence of any masses which are not faeces
- If any non-faecal mass is detected terminate the procedure, document findings and report to MO
- Gently withdraw finger
- Examine withdrawn finger for blood, mucous and colour of stool
- Discard contaminated glove and perform hand hygiene
- EN performing procedure discusses findings and treatment plan with RN

Document the following in the clinical notes in eMR and on the eMR Bowel Chart:

a) Assessment findings
   - Presence of stool
   - Consistency of stool if present
   - Sphincter tone
   - Characteristics of rectal wall i.e. dilated, collapsed.
   - Presence of haemorrhoids or fissures
   - Whether further review is indicated and when (refer to Appendix E)

b) Procedure outcome including abandoning the procedure if required.

Appendix C: Procedure for Administration of an Enema

All patients requiring the administration of an Enema – must have a DRE performed by a clinician suitably trained in the procedure

Types of Enemas

Olive oil enema

Olive oil (100-150mL) is retained in the rectum overnight to soften hard or impacted faeces to allow easier evacuation. Do not expect immediate results. The enema may need to be repeated daily before evacuation is achieved. Efficacy depends on the patient's ability to retain the oil. This is usually administered in conjunction with oral aperients or followed by stimulant suppository 12 hours after oil administration.

Specific instructions for the Administration of a Fleet Enema at POWH

- An irrigation / enema cone must be used for the administration of a Fleet enema.
- Note: If a patient is deemed to be a bariatric patient, please contact your educator to be advised on a suitable attachment that can be connected to the nozzle of the Fleet enema instead of the cone. This will ensure the Fleet enema solution is delivered accurately and safely via the rectum due to the patient's body habitus.
- A DRE must be performed at least once by a medical officer, usually at the time of prescribing the Fleet enema.
- It is recommended that two nurses are present during the administration of a Fleet enema

Administration of a Fleet Enema

Equipment

- Single use sachet of lubricant
- Enema
- Underpad such as blue sheet
- Disposable gloves / apron / protective eye wear
- The irrigation / enema cone is a soft silicone cone that gently inserts into the rectum in order to safely administer a Fleet enema.
- The irrigation / enema cone **must** be used for the administration of a Fleet Enema at **POWH**

- The tip of the fleet enema is inserted into the irrigation/enema cone tubing and air expelled prior to use

Generic Procedure for the Administration of an Enema

1. Identify patient & explain procedure and gain consent
2. Place patient in the left lateral position (as per picture below) with a pad under the buttocks

3. Tilt the head of the bed slightly downward to prevent leakage.
4. Put on disposable gloves and other personal protective equipment as required
5. Perform DRE examination as per Appendix B.
6. Lubricate the enema or irrigation / enema cone and gently insert into the anus and administer the contents of the Enema Fluid.
7. **If enema or irrigation / enema cone does not insert freely or patient complains of pain, stop immediately and seek medical advice before continuing.**

Generic Procedure for Post Administration of an Enema

8. Remove the enema or irrigation / enema cone and clean anus and buttocks
9. Have pan or commode nearby for patient to use or assist them to the toilet.
10. Instruct the patient to retain the contents of the enema for as long as possible (aim for 15-20 minutes).
11. Document the amount and type of enema and the results. in the eMR bowel chart
12. Any complaints of abdominal pain, rectal pain, rectal bleeding, back pain or fever must be promptly and thoroughly evaluated
13. If large volume of faecal output occurs consider possibility of electrolyte imbalance

Preparation of an Olive Oil Enema

- Pour prescribed amount of fluid into an enema bag
- Place enema bag into a bowl of warm water to heat to a tepid temperature.
- Prime tubing to remove air

Perform the Generic Procedure for the Administration of an Enema Steps – 1-7

- Insert rectal catheter of the enema bag in an upward and backward direction for a distance of up to 10cm and hold the catheter in position
- **If catheter does not insert freely or patient complains of pain, stop immediately. A mild sensation of the tube being inserted and the enema fluid flowing is expected. Seek medical advice before continuing**
- Attach enema bag to IV pole and allow fluid to slowly flow in.
- Carefully monitor how much fluid the patient can tolerate, usually up to 100 - 150mL can be safely administered; terminate procedure if the patient experiences pain and/or cramps
- If the patient feels like expelling the solution reduce or stop the flow. After the desire to expel the solution has subsided, continue to allow the solution to flow in.

Perform the Generic Procedure for Post Administration of an Enema - Steps – 8-13

Appendix D: Procedure for Manual Disimpaction

- Manual disimpaction is not routinely recommended and is used only when other methods of relieving severe constipation have failed. It should only be carried out in consultation with an experienced medical officer.
- Appropriate caution must be used in elderly patients and ensure that consent is taken from substitute decision maker if patient is not able to consent due to significant cognitive impairment.
- Manual disimpaction is not the designated responsibility of either the RN or MO but rather the most experienced clinician
- Patients are not to be asked to perform self-disimpaction.
- Consult the Palliative Care Team for palliative patients who may require manual faecal disimpaction.
- **SSEH** – Manual Disimpaction **must** be performed by a medical officer.
- Consider early referral to a general surgical team for patients who experience discomfort which would prevent this procedure being carried out on the ward.

Procedure

1) Pt may need a mild sedative pe procedure – as per medical team
2) Insert 30mL – 60mL of olive oil rectally via rectal tube if possible
3) Use 1 finger to gently digitally disimpact rectum so as not to tear or damage the rectal wall
4) Clear remaining colon with follow up olive oil enema if required
5) Prevent reoccurrence by titrating regular aperients /establishing appropriate bowel management regime and monitoring fluid/food intake.

Appendix E: Interventions Related to DRE Findings