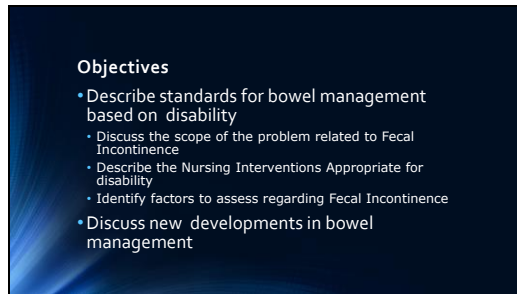


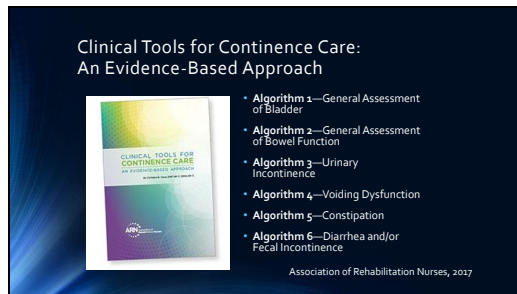
Slide 1



Slide 2



Slide 3



Slide 4

Clinical Tools for Continence Care

General Assessment of Bowel Function

- Risk Factors
- Screening
- Physical Assessment
- Data
- Identify Primary Bowel Symptoms
- Plan of Care

Constipation (No Bowel Movement in 3 days or more)

Diarrhea or Fecal Incontinence

Slide 5

General Assessment of Bowel Function

- Risk Factors for Bowel Dysfunction
- Screening Questions
- Conduct a Physical Assessment
- Collect Data
- Identify Primary Bowel Symptoms: Initiate a Plan of Care
 - Patients with Risks
 - Patients with no BM in 3 or more days
 - Patients with Fecal Incontinence or diarrhea

Slide 6

Risk Factors for Bowel Dysfunction

- Cognitive impairment/ memory impairment
- Limited mobility
- History of bowel disturbance
- Recent surgery
- Medications with adverse side effects
- Dysphagia/NPO status or Tube Feedings
- History bowel obstruction
- History of bowel disease

Slide 7

Interview- Screen for Bowel Dysfunction

- New Bowel problems?
- Problems with normal bowel movements
- Problems in the past
- What is your normal stooling pattern? How often do you move your bowels?
- Have you used medications for bowel function in the past?
- Do you sometimes leak stool when you intend to pass gas?

Slide 8

Risk Factors for Bowel Dysfunction

- Neuro Exam
- Oral/Swallow
- Abdominal
- Perianal skin
- External Anal Reflex
- Internal Anal Reflex

Slide 9

Collect Data

Chart Review

- Current Diet- Fiber content
- Hydration status vs. Fluid needs (2L -3L/day)
- Last bowel movement and stool consistency
 - Bristol Stool Scale
- Medication Review
- Elimination Chart – Frequency and Form x 7 days
- Bowel accidents? What were circumstances?

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Bristol Stool Scale

Type	Description
Type 1	Hard, lumpy, and difficult to pass
Type 2	Hard, soft on the outside, but lumpy on the inside
Type 3	Like a sausage with some cracks on its surface
Type 4	Like a smooth, soft sausage or snake
Type 5	Soft, fluffy pieces with ragged edges
Type 6	Very soft, mucous, and difficult to hold
Type 7	Watery, loose, and often urgent

Slide 11

Patterns of defecation through the lifespan

- Infants
- Children
- Adults
- Older Adults

- Gut functions at reflex level
- Develops cortical control over the time and place of defecation
- Intense activity and relative regularity, may vary with diet changes. The bowel responds to simple interventions
- Changes occur in striated and smooth muscle
- Activity decreases
- Diet changes
- Decreased water
- Comorbidities

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Identify Primary Bowel Symptoms & Initiate a Plan of Care

- Patients with Risks
- Patients with no BM in 3 or more days
Algorithm 5: Constipation
- Patients with Fecal Incontinence or diarrhea
Algorithm 6: Fecal Incontinence or Diarrhea

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Slide 14

Clinical Tools for Continence Care

General Assessment of Bowel Function

Constipation (No Bowel Movement in 3 days or more)

- Transient/Simple
- LMN Neurogenic Bowel
- UMN Neurogenic Bowel
- Obstructed
- Normal Transit Constipation/ IBS
- Slow Transit Constipation

Diarrhea or Fecal Incontinence

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Prevention of Constipation

- Good toileting habits
- Upright Position (left-side lying if upright impossible)
- Use toilet
- 20-35 grams of fiber per day
- 2-3 liters per day
- Exercise program
- Pharmacologic treatment, short-term

RNAO 2005 guideline LOE 4

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Requirements for stool formation and normal bowel function

- Adequate fiber
- Adequate fluid
- Activity and mobility
- Upright posture

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Transient/Simple Constipation

- Good toileting habits
- Upright Position (left-side lying if upright impossible)
- Use toilet
- 20-35 grams of fiber per day
- 2-3 liters per day
- Exercise program
- Pharmacologic treatment, short-term

RNAO 2005 guideline LOE 4

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Types of Impaired Bowel function

Acute Constipation

- Recent onset

Chronic constipation

- Severe constipation-lasting longer than 3 months
- Sympathetic System Response
- Enlarges descending colon
- Dependency
- Laxatives
- Cathartics
- Enemas

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Lower motor neuron

- SCI damage below T₁₂-S₁
- No cortical control
- Lack of tone at internal and external sphincters
- Damage to reflex arc
- Oozing of stool

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Upper motor neuron

- May be reflexive emptying of bowel without cortical awareness
- Damage to spine above T₁₂ or damage to cerebral cortex
- May be aware of need to defecate but have no conscious control

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Obstructed Constipation

Causes

- Pediatrics- most frequently congenital
- Adult- hernia, adhesions, carcinoma
- Elderly- carcinoma, diverticulitis, sigmoid volvulus

Presents

- Colicky pain
- Emesis
- Abdominal distention
- Constipation

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Normal Transit Constipation/IBS

- Transit time through the bowel is normal
- Medications
 - Antihypertensive drugs
 - Antidepressants
 - Iron
 - Aluminum containing drugs
 - Analgesics – opiates and cannabinoids
 - Anti-Parkinson, antiepileptic and antipsychotic drugs
- Diet or dehydration
- Irritable bowel syndrome with constipation

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Slow Transit Constipation/IBS

- Low Fiber Diet
- Dehydration
- Lack of exercise
- Delaying impulse to have bowel movement
- Travel or changes in routine
- Medications

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Clinical Tools for Continence Care

General Assessment of Bowel Function

Constipation (No Bowel Movement in 3 days or more)

Diarrhea or Fecal Incontinence

- Manage the Diarrhea
- Regulate Stool Pattern and Control Fecal Incontinence

Slide 25

Diarrhea or Fecal Incontinence

Acute Diarrhea with Urgency or Fecal Incontinence

- Watery
- Bloody
- Mucous/Fatty/Foamy

Chronic Diarrhea

- Purulent, Watery
- May alternate with constipation

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Interventions

ACUTE DIARRHEA	CHRONIC DIARRHEA
<ul style="list-style-type: none">• Collect a stool culture• Treat infection if present• Medication reconciliation• Adjust meds or discontinue	<ul style="list-style-type: none">• Crohn's disease• Diverticulitis• Irritable bowel disease• Ulcerative colitis• Colon cancer• Radiation colitis

Slide 27

Manage the Diarrhea

- **Hydration**- hydration support- IVF if needed
- **Mild diet**- BRAT
- **Medications**- Hold laxatives/stool softeners
- **Antibiotics**- not recommended in non-severe watery diarrhea unless elderly, immunocompromised, severely ill or history of sepsis
- **Probiotics**- consider if inflammatory bowel disorders or recent antibiotics
- **Skin** -good hygiene

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Treatment

Treat underlying constipation and rule out impaction
Promote Diet with natural fiber
Pelvic Floor/ anal sphincter exercises with PT
Consider every 3rd night suppository
Good Skin Care

OR

Establish a Neurogenic Bowel Program

Slide 29

Bowel management goals are best achieved through interdisciplinary team goals

key factors in the choice of appropriate bowel management strategies

- Cognitive ability
- Communication ability
- Hand function
- Level of independence in ADL
- Transfers

Slide 30

Bowel Management: Research and Alternate Treatment Options



Slide 31

SCI Bowel Care and Autonomic Dysreflexia

SPINAL CORD, 2014 **ARCHIVES OF PHYSICAL MEDICINE AND REHABILITATION, 2002**

"In the present study, all subjects with high SCI had AD during bladder filling, digital anorectal stimulation and transanal colorectal irrigation." (n=8)
Faaborg, et al, 2014

Silent Dysreflexia:

- During the bowel program, no subject reported experiencing any of the classic symptoms of autonomic dysreflexia.
- All of the patients had an increase in SBP greater than 20mmHg above baseline.
- 79% had an increase in SBP greater than 40mmHg above baseline.
- 40% of subjects reaching an SBP greater than 170mmHg at least once during their bowel program

Kirshblum, House, O'Connor, 2002

Slide 32

Spinal Cord Bowel Management

DIL

- Digital stimulation- continuous or with short breaks
- Stimulation lasts longer than 30 seconds
- Continue 5 minutes after no further results


DIGITAL STIMULATION

- Insert suppository
- Wait 15-20 minutes
- Digital stimulation every 10 to 15 minutes
- Until no results x 2

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Perform the dil (digital stimulation)

- Put gloves on both hands or place dil stick in the hand
- Lubricate index finger or dil stick
- Gently put finger or dil stick into the rectum past the sphincter
- Gently move the finger or dil stick in a circular motion
- When the stool begins to empty from the rectum, move the finger or dil stick to one side or remove so stool can pass.
- Do this for at least 20 minutes if no stool is coming. If stool is produced, do the dil as long as stool is coming and dil for five additional minutes afterward without getting any more results.
- You may need to gently remove stool from rectum with your finger if it does not come out on it's own.





Copied from
www.myShepherdconnection.org

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Anal Irrigation System

Anal irrigation is an alternative to other methods such as laxatives, suppositories and mini enemas. It requires a doctor's order.



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Antegrade Colonic Enema (ACE)

MALONE ANTEGRADE CONTINENCE ENEMA (MACE)

- ACE procedure is an alternative for patients with chronic fecal incontinence or constipation for who more conservative treatment has been unsuccessful.
- It is an alternative to a colostomy for a patient who does not want to wear an external stoma appliance.
- Colonic irrigation is a permanent solution and it requires a motivated patient and educated, supportive nursing staff.
- Stomal stenosis is the most common complication of the procedure.

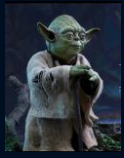
Types of ACE

- original cecum ACE
- new left colonic ACE



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- o Incontinence can profoundly affect the client's Quality of Life
- o Nursing interventions can make a significant difference in quality of life and lifestyle.



Slide 40

Functional Independence Measure

- **4 (Minimal Contact Assistance) Minimal Contact Assistance**—Pt requires minimal contact assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. Pt performs 75% or more of bowel management tasks in the past 3 days. (Helper.)
- **3 (Moderate Assistance)** The pt requires moderate assistance to maintain a satisfactory excretory pattern by using suppositories, enemas, or an external device. The patient performs 50-74% of bowel management tasks in the past 3 days. (Helper.)
- **2 (Maximal Assistance)** Pt performs 25-49% of bowel management tasks in the past 3 days. (Helper.)
- **1 (Total Assistance)** Pt performs less than 25% of bowel management tasks in the past 3 days. (Helper.)

Accidents

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Functional Independence Measure Function

- **7 (Complete Independence)** The pt controls bowels completely and intentionally w/o equipment or devices, and does not have any bowel accidents. (No Helper.)
- **6 (Modified Independence)** The pt requires a bedpan, bedside commode, digital stimulation or stool softeners, suppositories, laxatives (other than natural laxatives like prunes), or enemas on a regular basis; alternately, the pt uses other medications for control. If the individual has a colostomy. (No Helper.)
- **5 (Supervision or Setup)** Supervision or Setup—The pt has required supervision (e.g., standby, cueing, or coaxing) or setup of equipment necessary for the individual to maintain either a satisfactory excretory pattern or an ostomy device at any time during the past 3 days. (Helper.)
