COMPREHENSIVE BOWEL MANAGEMENT PROGRAM

1. **Policy:** A comprehensive bowel management program which emphasizes the utilization of diet, fluids, and activity to establish good bowel function and includes a pattern of bowel evacuation without the aid and dependence upon laxatives and/or enemas.

2. **Purpose:**
   a. To promote healthy bowel functioning and obtain an optimal level of health and activity for all residents.
   b. To prevent chronic constipation.
   c. To prevent fecal impactions.
   d. To prevent physical morbidity and mortality.

3. **Scope:** This operating procedure applies to all residents of Florida State Hospital who have identified issues of constipation or impactions and the staff who treat them. The Bowel Management Program shall become part of the overall Recovery Plan for these residents.

4. **Training Requirements:** Physicians and nurses will be trained on this operating procedure upon hire into the position during Discipline-Specific Education and by their supervisor each time the operating procedure is revised.

5. **References:**
   c. Taber’s Cyclopedic Medical Dictionary, 18th Edition.

6. **Definitions:**
   a. Anismus: Excessive contraction of the external rectal sphincter.
b. Anal Wink: Contraction of the anal sphincter in response to a stimulus of the perineum.

c. Bowel Incontinence: A state in which an individual experiences a change in normal bowel habits characterized by involuntary passage of stool.

d. Bowel Sounds: The normal sounds associated with movement of the intestinal contents through the lower alimentary tract, heard on auscultation. Absent or diminished sounds may indicate paralytic ileus or peritonitis. High pitched tinkling sounds or absent sounds are associated with intestinal obstruction.

e. Cathartic Colon: The inability to have a bowel movement without the use of a laxative.

f. Constipation: A state in which an individual experiences a change in normal bowel habits characterized by a decrease in frequency with passage of hard, dry stools. Clinically, bowel movement frequency of less than three times per week and if straining is experienced with more than 25% of bowel movements.

g. Defecation Reflex: The reflex which occurs when food residues reach the rectum and cause the urge to defecate. This sensation is related to periodic increase of pressure with in the rectum and contraction of the musculature.

h. Fecal Impaction: A condition when feces are tightly wedged into the bowel. Water has been reabsorbed by the bowel tissue causing the fecal mass to become hard and dry. Often this mass cannot be passed by the action of the musculature.

i. Gastrocolic Reflex: Peristaltic waves in the colon induced by the entrance of food into the stomach.

j. Ileus: An acute intestinal obstruction, characterized by sudden pain that is paroxysmal at first and then continuous, constipation, persistent fecal vomiting, abdominal distention, and eventually collapse. A mechanical ileus is produced by an obstruction such as a fecal impaction.

k. Intestinal Obstruction (Bowel Obstruction): A partial or complete blockage of the lumen of the large or small intestine. Auscultation of the abdomen may reveal a high-pitched tinkle or no sound at all.

l. Megacolon: An extremely dilated colon.

m. Sepsis: The spread of an infection from its initial site to the bloodstream, initiating a systemic response that adversely affects blood flow to vital organs. In cases of impaction, organisms in the gastrointestinal tract damage local cells and stimulate both the inflammatory and cell-mediated immune responses, resulting in the release of cytokines, which enhance immune defenses. When the organisms overwhelm those local defenses and enter the bloodstream, the resulting condition is called septicemia.

n. Valsalva Maneuver: An attempt to forcibly exhale with the glottis, nose, and mouth closed. Causes an increased intrathoracic pressure, slowing of the pulse, decreased blood return to the heart, and increased venous pressure. This maneuver is utilized to forcibly push the feces from the rectum.
3. Vagal Attack: A condition of dyspnea with cardiac distress and a fear of impending death. The sinking sensation associated with the attack is assumed to be the result of vasomotor spasm. The stimulation of the vagus nerve inhibits heartbeats.

7. General Considerations:

   a. A comprehensive bowel management program is recommended for all residents with identified chronic elimination problems of constipation, fecal impaction, and incontinence resulting from fecal impaction or any resident dependent on laxatives, stool softeners and/or enemas. It is also recommended for all residents unable to adequately toilet or hydrate themselves independently, e.g.: persons in seclusion, restraint, Forensic Secure Area, in wheel chairs or geri-chairs, and persons with dementia or other cognitive deficits.

   b. The initial management of constipation consists of a program of diet, fluids and exercise and a toileting regimen.

   c. Bulk and consistency of stool are influenced by dietary and fluid intake. High vegetable diets produce soft, bulky stools and high meat diets produce small, dry, hard stools. Our society generally focuses on diets high in meat and low in vegetables and fruits.

   d. Bowel patterns are culturally and/or familiarly determined. The range of “normal” is wide, from three (3) bowel movements per day to once every three (3) days.

   e. Bowel elimination is controlled by the somatic and autonomic nervous system. Defecation involves the coordinated relaxation of the puborectalis and external anal sphincter muscles simultaneously with increased intra-abdominal pressure forcing stool toward the rectum.

   f. Fluid intake, essential for adequate bowel functioning, is primarily regulated by the sensation of thirst. People who are confused, depressed, psychotic, elderly, or lethargic often do not perceive the sensation of thirst.

   g. Dehydration is the most common fluid and electrolyte disturbance among the elderly. Because it is associated with morbidity and mortality rates, careful screening and prevention is essential.

   h. Older adults experience reduced mucus secretion in the large intestine. The elasticity of the rectal wall is also decreased.

   i. A digital rectal exam is performed when constipation or impaction is suspected. If hard stool is present on exam, then disimpaction is necessary prior to initiating further interventions. Each digital rectal exam must have a physician’s order in order to be performed. Extra caution must be taken in residents who have identified cardiac problems as a digital rectal exam may initiate a vagal response/attack.

   j. Long-standing constipation or fecal impaction causes over-distention of the colon and rectum by the feces, sometimes resulting in megacolon. This causes continuous reflex stimulation which results in reduced sphincter tone, which in turn can lead to incontinence of liquid feces leaking around the impaction. **Fecal incontinence in the elderly is a predictor of impaction.**
k. Chronic laxative or enema use is often the cause of chronic constipation and a slowed fecal mass intestinal transit time that further contributes to constipation.

l. The treatment of constipation is often frustrating for the resident, physician, and nurse. Adherence to the basic principles described in this comprehensive bowel management program will ensure improvement in most residents.

m. Implementation of the comprehensive bowel management program needs coordinated efforts from all staff including the direct care staff as well as the resident's recovery team.

8. **Program Benefits:**
   a. Improvement in the resident’s elimination, health, well-being, and comfort.
   b. Reduction in the risk of colon cancer, diverticulosis, ulcerative colitis, toxic megacolon, functional megacolon, sepsis, high and low impactions, bowel obstruction, and ileus.
   c. Reduction in the use of laxatives, stool softeners, suppositories, and enemas.
   d. Reduction in nursing time spent administering those items mentioned in paragraph c above.
   e. Reduction in the number of uncomfortable procedures for the resident such as suppository insertion, enemas, digital examinations, and digital impaction removal.

9. **Residents Most Likely To Benefit From The Program:**
   a. All residents over age 55.
   b. Those residents who have less than 3 bowel movements per week and experience straining more than 25% of the time during defecation.
   c. Residents who have hard, dry stools.
   d. Residents who have abdominal distention, fullness, or bloating in the presence of rectal fullness and pressure.
   e. Residents who have an absence of bowel movements accompanied by an empty rectum on digital examination.
   f. Residents with rectal pain on passage of stool.
   g. Residents with feelings of incomplete evacuation of stool.

10. **Risk Factors for Constipation:**
   a. Age: older than 55.
   b. Surgery: recent abdominal or perianal surgery.
   c. Activity: limited activity or poor mobility or a generalized decline in physical activity.
d. Fluid Intake: inadequate fluid intake of less that 2000 cc/ml of fluids per day.

e. Medications: medications known to be associated with increased risk of constipation include:

   (1) anti-cholinergics;
   (2) anti-emetics;
   (3) anti-histamines;
   (4) analgesics/NSAIDS;
   (5) hypotensives;
   (6) anti-depressants;
   (7) antacids;
   (8) calcium supplements;
   (9) calcium channel blockers;
   (10) iron supplements;
   (11) aspirin;
   (12) barium (used in a barium enema) and upper GI Series;
   (13) phenothiazines;
   (14) narcotics;
   (15) anesthetics
   (16) anti-Parkinson agents;
   (17) steroids.

f. History of chronic constipation.

g. History of laxative or enema abuse.

h. Co-morbidities known to be associated with constipation:

   (1) renal diseases such as chronic renal failure, uremia, and status post renal transplant;
   (2) electrolyte imbalances such as acidosis, hypokalemia, and hypocalcemia;
   (3) spinal cord injuries;
(4) debilitating physical conditions such as arthritis and heart disease;

(5) gastrointestinal conditions such as painful lesions in the rectal or anal region, fissures, perirectal abscesses, diverticular disease, inflammatory bowel disease, colon cancer, and obstructing neoplasms;

(6) neurologic conditions such as Parkinson’s disease, ALS, multiple sclerosis, and stroke;

(7) poliomyelitis;

(8) endocrine conditions such as insulin dependent diabetes, untreated hypothyroidism, hypercalcemia, and hypoparathyroidism;

(9) mental and emotional states such as depression, dementia, psychosis, Alzheimer’s, and acute or chronic confusion.

i. Changes in life routines (such as hospital admissions)

11. Assessment:

   a. General assessment: A data base including the presence of causes and contributing factors for the resident’s bowel problem will be determined. This data will be utilized to formulate a plan of care specific and appropriate for the resident.

   (1) Obtain a dietary history including any foods and fluids that have caused constipation, loose stools or diarrhea, flatus, or gastric distress.

   (2) Record the resident’s usual (when well) and present bowel patterns, including frequency, amount, consistency and time of day that elimination most often occurs.

   (3) Identify environmental stimuli that aid in evacuation such as a cup of coffee, reading, privacy, glass of hot water, personal bathroom, etc.

   (4) Ask the resident if he/she can identify symptoms of constipation such as headaches, a feeling of fullness, pain, restlessness, etc.

   (5) Learn the resident’s pattern of exercise, type and amount both past and present.

   (6) Question for use of laxatives and/or enemas including the type, amount, and frequency.

   (7) Determine what medications the resident has been taking that can cause constipation. (See types of medications listed above that can cause or contribute to constipation.)

   (8) Ask if there are any other factors which may be contributing to constipation such as hemorrhoids, anal fissures, fistulas, growths, or recent surgery.

   (9) Consider the type of psychiatric illness the resident has such as depression, confusion, psychosis, etc.
b. Physical Assessment:

(1) Bowel sounds: Auscultate in all four (4) quadrants of the abdomen and note whether bowel sounds are present. Are they hypoactive, hyperactive, or absent? Are the sounds high-pitched, gurgling, loud, or weak?

(2) Palpate abdomen: Lightly palpate abdomen, then palpate more deeply, but carefully. Determine if there are masses, tenderness, rigidity, pain, etc.

(a) Abdominal distention: Is the abdomen slightly, moderately, or severely distended? Or is there no distention? Is the abdomen rigid?

(b) Abdominal pain: Was there pain or tenderness on palpation of the abdomen?

(c) Abdominal masses: Were masses noted on palpation? What was the shape and size of the palpated mass?

(3) Flatulence: None, occasional, or frequent

(4) Digital rectal examination: After the above assessments have been completed, have the resident lay on the right side for the perianal and rectal examination. Prior to insertion of a lubricated gloved finger, note the presence of any hemorrhoids, fissures, irritation, control of the rectal sphincter (was there an anal wink?). To relax the anal sphincter and prepare the resident for the insertion of the finger, place the finger against the anus for a few seconds prior to the insertion. Note the tone of the anal sphincter. Note the presence or absence of fecal material in the rectum/vault. If stool is present, is it soft or hard and dry. If there is a hard, dry mass of feces present, break up the mass and gently extract whatever stool that can be extracted. Note the resident’s reaction throughout the procedure. Note any discomfort, dizziness, nausea, or other sensations that would indicate that the procedure needs to be stopped. A rectal digital exam must be ordered by a physician prior to being performed.

(5) Weight gain or weight loss: Has the resident gained or lost weight recently?

(6) Temperature: Take the resident’s temperature. It is often elevated, especially in the older adult with an impaction.

c. Subjective Data: When a resident complains of constipation, ask questions about the following subjective experiences:

(1) feeling nauseated;

(2) decreased appetite/anorexia;

(3) feeling of abdominal fullness;

(4) pains in the abdomen;

(5) increased gas production;

(6) headaches;
(7) straining;
(8) persistent feeling of pressure on the rectum;
(9) generalized weakness;
(10) lethargy;
(11) thirst;
(12) cramping.

12. Interventions for the Bowel Management Program: After the data has been collected and the resident examined, the information will be used to develop a plan of care to assist the resident regain an acceptable pattern of elimination. The following areas need to be addressed when developing the plan.

a. Establish a routine or habit for elimination:

(1) Determine a suitable time daily to attempt defecation. Consider, but do not be bound by the time of day formally used, if factors indicate a new time is presently desirable. Encourage the resident to notify you of any urges to defecate at any other time of the day or night and be prompt to take advantage of that natural urge.

(2) Reproduce helpful environmental stimuli that have been successful for the resident in the past (i.e., privacy, reading material, coffee, tea, hot water, etc.) when able.

(3) Position in a sitting position with the feet pressing on a flat surface. Maintaining a slight knee-chest position is known to facilitate a natural bowel movement. Bed-fast residents should bend their knees if able and press their heels against the bed. Raise the head of the bed to the upright position if possible based on the resident’s condition.

(4) Instruct the resident in the following breathing pattern: using abdominal breathing, have him/her take three, long, slow breaths, then tighten abdominal muscles.

(5) If the resident is unable to defecate, have him/her try at other times of the day. After meals the gastrocolic reflex is stimulated by the presence of food in the stomach, so this is often a good time to attempt evacuation. Other times to attempt defecation are after exercise or Physical Therapy.

b. Nutritional Management:

(1) People with constipation generally do not get enough fiber in their diet. A high fiber diet increases the frequency and bulk of bowel movements. The fiber acts like a sponge by absorbing water from the colon and propelling the mass through the colon faster therefore removing waste more quickly. There are two types of fiber, each important to the diet. Soluble fiber is contained in food such as oat bran, barley, some beans and certain fruits and vegetables. This type of fiber forms a gel with water. Insoluble fiber such as wheat bran, vegetables such as celery, and whole grains does not dissolve in water. This is the type most helpful in the prevention of constipation. A combination of both types of fiber is most effective. Fluid intake must be at least 2000 cc per day with a high fiber diet or the fiber may promote the formation of impactions. High fiber diets are NOT recommended for
residents who are immobile or who consume less than the required 2000 cc of water per day. The High Fiber Diet needs to be discontinued by the physician until the resident is consuming at least 2000 cc per day.

(2) The diet prescription needs to be made based on the assessment data in consultation with a dietitian. Foods which cause constipation or flatus for the resident need to be eliminated as much as possible. High fiber foods need to be added to the diet if the resident can tolerate them. These include bran cereals, whole wheat breads, brown rice, cauliflower, turnips, Brussels sprouts, broccoli, cabbage, corn, peas, carrots, peanuts, apples (with peel), pears (with peel), grapes, prunes, figs, and raisins. An order for prune juice at bedtime may also be helpful.

c. Hydration:

(1) As noted above, for effective bowel movements, 2000 cc of fluids are recommended per day. Caffeinated drinks such as coffee, some sodas, and tea as well as alcohol act as diuretics and should not be counted in the overall total intake of fluids. Water, juices, soups, milk, popsicles, non-caffeinated beverages, and other fluids should be counted.

(2) Dehydration is one of the key elements in the formation of constipated stools and impactions especially among older populations. Therefore, prevention of dehydration is critical to the overall well-being of the resident.

(a) Defining characteristics of dehydration:

1. insufficient fluid intake;
2. negative balance of intake and output;
3. weight loss;
4. dry skin and mucous membranes (lips, gums are dry);
5. increased serum sodium;
6. decreased urine output or frequency of output;
7. decreased skin turgor;
8. thirst, nausea, or anorexia;
9. thready pulse;
10. decreased venous filling;
11. decreased cardiac output;
12. increased pulse and respirations;
13. increased temperature (especially in the elderly);
14. concentrated urine which appears dark amber or large output of urine which is very light in color;

15. increased hematocytes.

(b) Causes of dehydration:

1. decreased motivation to drink;
2. inability to drink unassisted;
3. cognitive dysfunction which prohibits the individual from feeling thirsty/perceiving thirst, in the older adult there is a decreased sensation of thirst;
4. excessive laxative or enema use;
5. weather: heat and sun;
6. diuretic usage;
7. illnesses which cause vomiting, diarrhea, and/or fever.

(c) Dehydration in the elderly: The older adult is more susceptible to fluid loss and dehydration due to:

1. decreased % of total body water;
2. decreased renal blood flow and glomerular filtration;
3. impaired ability to regulate body temperature (this is further compromised when the resident is on psychotropics);
4. decreased ability to concentrate urine;
5. physical disabilities which decrease the individual’s access to fluids;
6. diminished thirst sensation.

(d) Prevention of dehydration:

1. monitor fluid intake and output;
2. monitor serum electrolytes, urine, BUN, osmolality, creatinine, hematocrit, hemoglobin;
3. offer fluids frequently; at each meal offer at least 16 ounces or more, and one 240 cc cup (8 ounces) between meals and at bedtime (HS);
4. review current medications for any that may be contributing to dehydration.

(3) There are several instances when caution should be exercised regarding fluid intake:
(a) residents who drink fluids excessively should not be encouraged to drink fluids and may need to be on fluid restriction per physician’s order if the situation warrants;

(b) residents who have hyponatremia may need to be restricted from excess fluid intake;

(c) residents with a history of or active Congestive Heart Failure may need fluid restrictions per physician’s orders.

d. Exercise: Exercise is another important component in promoting the ability to maintain regular bowel movements.

(1) Exercise must be tailored to the individual’s ability and medical condition.

(a) Walking for 15-20 minutes every day or twice per day for those individuals who are completely mobile.

(b) Ambulating at least 50 feet twice per day for those with limited mobility.

(c) Chair and/or bed exercises including the pelvic tilt, low trunk rotation, and leg lifts for 15-20 minutes twice per day for those who are bedridden.

(2) Exercise promotes the muscle tonicity needed for fecal expulsion as well as increases circulation to the digestive system.

e. Laxatives: When the above interventions are not enough to promote consistent evacuation, laxatives may be used. The natural laxative effect of prune juice and bran may be tried prior to utilization of the laxatives listed below. Four (4) to eight (8) ounces of prune juice prior to bedtime or twice per day, may facilitate a bowel movement the next morning. A physician’s order on the treatment order sheet or diet order (Form 99) is required for prune juice.

(1) All laxative use needs to be reduced or eliminated when initiating the above interventions (establishing a routine, diet, fluids, and exercise).

(2) Use a laxative ONLY as a supplement to the other interventions.

(3) Use a laxative if the resident has not had a bowel movement for three consecutive days.

(4) Laxative use is most effective when ordered in the following progression:

(a) Bulk-forming laxatives: Psyllium hydrophylic muculoid. **NOTE:** Older adults who consume insufficient amounts of fluids in combination with bulk-forming laxatives are predisposed to fecal impactions and bowel obstructions.

(b) Stool softeners: Docusate sodium. Stool softeners are recommended for residents who should avoid straining.

(c) Osmotic laxatives: Lactulose, Sorbitol, or magnesium sulfate (MOM). These laxatives lower the stool pH causing distention of the bowel that then stimulates
evacuation. Be aware that the older adult may experience diarrhea, dehydration, and fluid/electrolyte imbalance with this type of laxative.

(d) Stimulants: Senna, Dulcolax, cascara, castor oil, Senokot. Stimulants stimulate peristalsis in the distal colon which causes mass movement of softened stool. Older adults may require up to 10 weeks of use to establish a regular pattern of elimination. However, they also may develop loss of electrolytes, vitamins, and normal bowel flora, fluids and dehydration secondary to diarrhea.

(e) Suppositories and enemas: Glycerin suppository, Bisacodyl, Sodium/Potassium phosphate enema. These stimulate evacuation in response to colonic distention. Perforation of the colon and electrolyte imbalance can occur with these. They also overstretch the bowel and decrease the bowel tone.

(5) Laxative orders may run no longer than thirty days.

(6) Cleansing enemas can only be ordered STAT, not PRN.

(7) Mineral oil and wetting agents (Surfak) may not be used together due to the increased absorption of the mineral oil. Also, mineral oil should not be used orally with the elderly or with persons who have an aspiration issue as the oil may be aspirated, causing an aspiration pneumonia.

(8) Laxative use can cause unscheduled bowel movements, loss of colon tone, and inconsistent stool consistency, all of which are contrary to normal bowel functioning.

(9) All laxatives will be stopped by the nurse if the resident develops diarrhea and the physician will be notified.

13. **Documentation:**

   a. Documentation of the resident’s bowel movements, whenever there is an identified problem, is essential for choosing appropriate treatment options. Below are the characteristics of the stool that need to be documented.

   (1) Consistency: hard, formed, soft formed, liquid/diarrhea, pasty

   (2) Color: dark brown, medium brown, light brown, red, black (“tarry”), white/tan (“clay colored”), green, yellow

   (3) Amount: small, medium, large

   (4) Size: large, small, normal, pieces

   (5) Shape: round, narrow, large caliber, small caliber

   (6) Odor: normal, foul

   (7) Components: blood, pus, mucus, parasites, undigested food

   b. Documentation in the progress notes of all laxatives and enemas given, as well as the results, is essential to determine the effectiveness of the intervention.
SUMMARY OF REVISED, ADDED, OR DELETED MATERIAL
This operating procedure was revised to spell out abbreviations/acronyms; and change Service Implementation Plan to Recovery Plan and service team to recovery team.
1. The goal for all Florida State Hospital Residents is to have regular, soft bowel movements, consistent with the individual’s “normal” patterns of defecation.

2. The initial management of constipation consists of adequate fluids: at least 2000 cc per day; a diet adequate in fiber; exercise; and a regular time for toileting.

3. In the elderly, fecal incontinence is a predictor of impaction.

4. Risk factors for constipation are: over 55 years old, recent abdominal or perianal surgery; limited exercise and activity; inadequate fluid intake; medications that have a side effect of constipation; history of chronic constipation; history of laxative or enema use; certain medical co-morbidities; life changes that cause a change in the individual’s routine time for defecation.

5. Assessment of the resident for constipation includes a general assessment and history of bowel habits, a physical assessment, and the resident’s subjective thoughts and feelings.

   a. General Assessment:

      (1) Diet history including foods or fluids that cause constipation, diarrhea, flatus, or gastric distress.

      (2) Usual bowel patterns: frequency, amount, consistency, time of day of elimination.

      (3) Environmental stimuli that assist with defecation such as hot fluids, reading, etc.

      (4) Recognition of symptoms of constipation: headaches, fullness, pain, restlessness.

      (5) Patterns, type, and amount of exercise.

      (6) Laxative and /or enema use including type and frequency.

      (7) Medications that are being taken that have the side effect of constipation.

      (8) Presence of depression, confusion, psychosis, etc.

      (9) Contributing factors: hemorrhoids, fistulas, fissures, growths, recent surgery.

   b. Physical Assessment:

      (1) Bowel sounds: auscultate in all 4 quadrants of abdomen (hypoactive, hyperactive, high-pitched, gurgling, loud pushing, weak, absent).

      (2) Palpation:

         (a) Abdominal distention
(b) Abdominal pain

(c) Abdominal masses (Size, shape, location.)

(3) Flatulence

(4) Digital rectal exam: (must have a physician’s order)

(a) resident to lay on right side

(b) examine exterior or anus and rectal area for fissures, etc.

(c) note tone of anal sphincter during exam

(d) note presence or absence of fecal material. Is it dry, hard, soft, etc.

(e) break up any dry, hard impacted stool

(f) note resident’s reaction to procedure

(g) if resident becomes dizzy and/or nauseated stop the procedure

(5) Weight gain or loss

(6) Take resident’s temperature. (Often elevated in the elderly when impacted.)

c. Subjective Experiences: Ask the resident questions regarding the following: Nausea, decreased appetite or anorexia, abdominal “fullness”, abdominal pains, increased gas, headaches, straining, pressure on the rectum, generalized weakness, lethargy, thirst, cramping.

6. Bowel Management Program - Interventions:

a. Establish a routine or habit for elimination.

b. Dietary Management:

(1) Increase fluids to at least 2000 cc per day.

(2) Increase fiber intake (Do not increase fiber unless the resident is consuming at least 2000 cc of fluid per day as the increased fiber may promote impaction formation.)

c. Hydration:

(1) As noted above, 2000 cc is the minimum recommended amount of fluids per day for effective elimination.

(2) Defining characteristics of dehydration: decreased or insufficient fluid intake, negative balance between intake and output, weight loss, dry skin and mucous membranes, increased serum sodium, decreased urine output or frequency, decreased skin turgor, thready pulse, thirst, nausea, anorexia, decreased venous filling, decreased cardiac output, increased pulse
and respirations, increased temperature, concentrated urine or large output of urine which is very light in color, increased hematocytes.

(3) Prevention of dehydration: monitor I&O; monitor serum electrolytes, urine, BUN, osmolality, creatinine, hematocrit, and hemoglobin; offer fluids frequently - at least 16 oz. (480 cc) each meal and 240 cc between meals and HS; review current medications that may be contributing to dehydration. CAUTION: Residents who drink excess fluids, have hyponatremia, or have active/ history of CHF should be monitored for excess fluid intake and fluids should not be pushed.

d. Exercise:

(1) Tailor to the resident’s ability and medical condition.

(2) Walking 15-20 minutes per day or BID for residents who are mobile.

(3) Ambulating 50 feet BID for resident’s with limited mobility.

(4) Chair or bed exercises 15-20 minutes BID for non-ambulatory residents.

e. Laxative Use:

(1) Discontinue or reduce laxative usage when initiating the above interventions (routine, diet, fluids, and exercise).

(2) Prune juice 8 oz. at bedtime or BID has a “natural” laxative effect.

(3) Use laxatives only as a supplement to other interventions - not on a regular basis.

(4) Give a laxative if the resident has not had a BM in the past 3 days.

(5) Laxatives are most effective when ordered in the following progression:

(a) Bulk forming - psyllium hydrophylic muculoid.

(b) Stool softeners - docusate sodium.

(c) Osmotic laxatives - Lactulose, Sorbitol, or MOM

(d) Stimulants: Senna, Dulcolax, Cascara, Castor Oil, Senokot

(e) Suppositories and enemas: Glycerin suppository, Bisacodyl, Sodium/Potassium Phosphate enema.

(6) Laxative orders are good for only 30 days.

(7) Cleansing enemas can only be ordered STAT, not PRN.

(8) Mineral oil and wetting agents such as Surfac may not be used together as the wetting agent causes increased absorption of the mineral oil.
(9) Oral mineral oil can cause aspiration pneumonia in the elderly or in persons with an aspiration problem, as well as prevent absorption of certain vitamins.

(10) If the resident develops diarrhea, all laxative use will be stopped by the nurse and the physician will be notified.

7. Documentation: Accurate, detailed documentation is essential.
   a. Consistency: hard, formed, soft formed, pasty, liquid/diarrhea
   b. Color: brown (dark, medium, light), white/tan (“clay”), black (“tarry”), yellow, green, red.
   c. Amount and size: small, medium, large amount; round, narrow, large or small caliber size.
   d. Odor: normal, foul.
   e. Components: blood, pus, mucus, parasites, undigested food.
   f. Document all laxatives and enemas given as well as results.