

Appendix 2

ELIMINATION LEARNING PACK

**This pack may be used as a learning aid for Care/
Support staff**

**This Learning Pack contains a brief outline of the following
areas:**

- **The Excretory system**
- **Bowel management**
- **Constipation**
- **Impaction**
- **Diarrhoea**
- **The Neurogenic bowel**
- **Autonomic Dysreflexia**
- **Laxatives**
- **Suppositories**
- **Digital removal of faeces (DRF)**
- **Peristeen Anal Irrigation**
- **Stoma care**

The Excretory system

ELIMINATION

Elimination is the body's natural process for getting rid of waste products and is essential for general health and well-being.

Many people with disabilities require additional assistance with either/ or both bowel and bladder elimination. This can come in many forms which will be discussed further. It is essential that, in order to provide proper care, one has an understanding of the process of elimination and that one is competent in performing the necessary procedures in a professional manner.

Large Intestine

Undigested food enters the large intestine where water and salt is absorbed by the intestinal lining. The large intestine collects waste from throughout the body. It extracts any remaining usable water and then removes solid waste. At six to seven meters long, it transports the wastes through the tubes to be excreted.

The residue, together with waste pigments, dead cells, and bacteria, is pressed into faeces and stored for elimination from the body. Depending on the individual this can take anywhere between 10 hours to several days.

Appendix This has no known function.

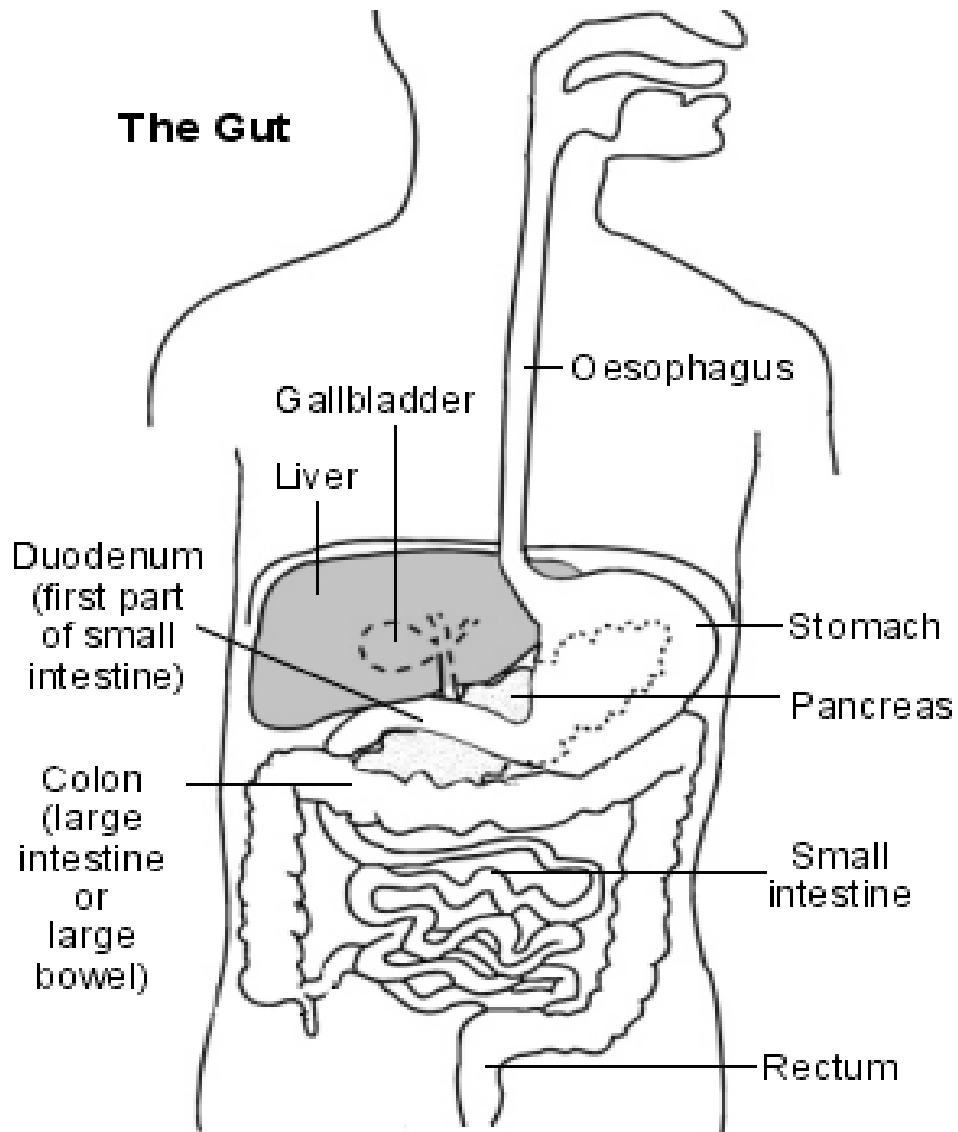
Rectum

Faeces accumulate in the rectum and are expelled from the body via the anus.

Anus

The digestive tract ends at this body opening. Two sphincters, internal and external which act like valves that relax during defecation, control it.

Please see diagram below



BOWEL MANAGEMENT

Loss of bowel function often affects people with neurogenic disorders (such as people with spinal cord injuries, spina bifida and multiple sclerosis.) It can affect people in different ways. Some people cannot control the discharge of faeces and are faecally incontinent, whilst others experience severe discomfort and bloating due to chronic constipation. Being taboo subjects, these conditions can not only be very difficult to talk about but also extremely distressing, due to the constant discomfort and/or anxiety of having an accident in public.

It is difficult for service users to discuss continence problems but it is important to talk to a health professional as there is help and support available.

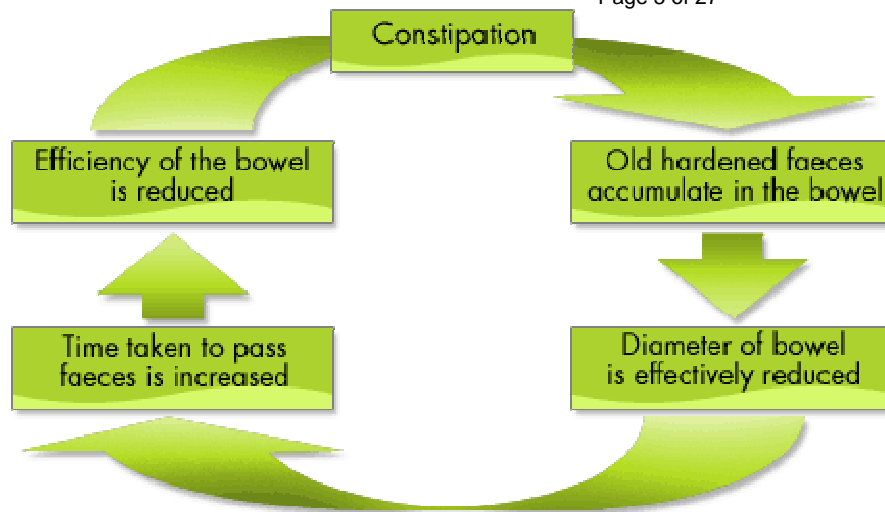
CONSTIPATION

Constipation is bowel elimination that is infrequent (Less than three times per week) and painful with hard faeces. It is distressing and if not properly managed can be a life threatening condition. Bowel movements vary from person to person and are affected by:

- Medications
- Diet
- Fluid intake
- Activity
- Lack of privacy
- Disease processes
- Underlying physical conditions.

A vicious circle

Waste that sits in the bowel for longer than is normal can cause the bowel wall to stretch and the muscles to function less efficiently. If it happens over a prolonged period it can become more difficult for waste to move through the bowel, which can make one become constipated again and so the vicious circle continues.



Bowel Management: prevention of course is the best method of management. Bowel management plans will include adjusting diet, increasing fluids and activity, administration of oral laxatives on a regular basis. People who are confined to a wheelchair or bed should change position often and perform abdominal contraction exercises and leg raised.

The primary aim of bowel management is to enable the service user to have:

- A regular bowel motion
- At a time and place that is socially acceptable
- Avoiding complications
- Maintaining their lifestyle.

The objectives

- Are to optimise safety, privacy and dignity during bowel management
- To assess needs and develop individual bowel programme
- To avoid complications
- To identify the physical/pharmacological intervention necessary
- To evaluate outcomes of bowel management (Bristol stool scale)
- Effective education.

Bowel plan

- Must specify the intervention used
- Frequency
- Timing am/pm
- Location (bed, commode, toilet)
- Who will perform the bowel care
- Effective bowel care in a reasonable time
(for someone with a spinal cord injury approx 1 hour).

Basis of bowel regime

- Faeces must be of the right consistency
- Faeces must be in the right place
- Evacuation occurs at the right time
- Reliable trigger is required to initiate motion /movement of the bowel
(peristalsis-muscle movement in the digestive-excretory system)
e.g. warm drink and small meal 1-2 hours before starting bowel at
breakfast.

The right consistency

- By achieving the right consistency the other principles are easier to achieve
- Adequate fluids
- Adequate fibre intake which increases bulk and stimulates peristalsis use
of additional bulking agents
- Using stool softener.

Constipation

Constipation is not a disease, it is a symptom of an underlying condition and peoples vary

Rome criteria for constipation requires that two or more symptoms be present for at least 12 weeks in the past 12 months

- Straining at defecation at least ¼ of the time
- Sensation of incomplete evacuation for at least ¼ time
- Three or fewer bowel movements per week.

Causes are:

- Incomplete or infrequent bowel care
- Inadequate diet or poor fluid intake
- High fatty low roughage diet
- Insufficient use of laxatives
- Medication
- Premenstrual.

Factors that contribute are:








- Loss of large bowel motor activity
- Loss of voluntary control of defecation
- Inactivity
- Change in daily routine.

Bristol Stool Scale

The Bristol Stool Scale or Bristol Stool Chart is a [medical](#) aid designed to classify the form of [human faeces](#) into seven categories.¹ The form of the stool depends on the time it spends in the [colon](#).

- The seven types of stool are:
- 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
- Types 1 and 2 indicate [constipation](#), with 3 and 4 being the "ideal stools" especially the latter, as they are the easiest to [defecate](#), and 5–7 tending towards [diarrhoea](#).

Bristol Stool Chart

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

IMPACTION

Impaction is the inability to pass stool due to severe constipation. When a person suffers from impacted bowel or bowel obstruction, the large mass in the rectum becomes so hard that it doesn't come out of the body. Sometimes, watery stool higher in the bowel can move around this large mass and cause soiling or diarrhoea. Also, constipation leads to serious discomfort in the person suffering from such a condition. This condition requires immediate attention.

Symptoms include

- Abdominal cramping
- Frequent straining with passage of liquid
- Rectal bleeding
- Small, semi-formed stools
- Sudden, watery diarrhoea in someone who has chronic constipation.

Causes of Impacted Bowel

Some people are at a higher risk of developing impacted bowels than others. The people who are at a risk are:

- Service users who are bedridden.
- Service users with severe diseases related to the nervous system
- People on anti-cholinergics drug; such drugs affect the interaction between specific nerves and muscles
- People on narcotic pain medicine
- People on methadone maintenance treatment for drug addiction
- People taking diarrhoea medication.

Treatment

Treating a faecal impaction involves removing the impacted stool, and taking measures to prevent constipation and future faecal impactions.

Medication: Bowel medicines are used to prevent further faecal impaction, and stool softeners are recommended like lactulose which help to pass soft stools out of the body. Enemas are also used to get rid of the impacted bowels.

Diet: A person is advised to increase the intake of fibres in their diet, when suffering from [bowel movement problems](#). Fibres help to regulate good bowel movements, and also help to get rid of fat in the body. The foods rich in fibre are dark green leafy vegetables, legumes and fresh fruits. A person is also recommended to take a lot of fluids when suffering from the condition of impacted bowel. Some service users with a Neurogenic bowel can find it hard to tolerate a high roughage diet and need to be referred to a dietician

Exercise: Regular exercising helps to maintain normal bowel movements. Service users who are confined to their bed or wheelchair should keep changing their position and perform [abdominal exercises](#) of contraction and leg raises. If it is possible the service users should do these exercise several times in the day.

Laxatives:

Where possible the most natural means of bowel evacuation should be used, i.e. introduction of fruit, fibre, exercise and increased fluids

These medications are best given at night to allow them to penetrate and soften the stool. It may be necessary to use them on a regular basis as part of a bowel management program. They should be given the night before the administration of suppositories/digital stimulation /digital removal of faeces.

Laxatives are medication products taken orally that loosen bowel contents and encourage evacuation. There are various types that differ in their functions, effectiveness and side effects.

Stool softeners such as Docolax/Movicol may be recommended to help pass soft, formed stools. Unlike other laxatives, stool softeners are used to prevent constipation by softening the stools. The ingredients in stool softeners do not stimulate bowel movement or irritate the intestine walls, but soften the stools and make their passage easier. Stool softeners have to be taken at bedtime and at least one to three days of regular use is required for better results. If a service user is taking stool softeners, they have to increase the intake of water and avoid the use of aspirin, mineral oils and lubricant laxatives.

Bulk fibre laxatives such as Metamucil /Lactulose/ Fybogel may be used to add fluid and bulk to the stool. Bulk-forming laxatives also take one to three days to become effective and they require that the user should drink lots of water.

Lubricant laxatives Glycerine, bisacodyl suppositories, or other gentle laxatives may be used along with a bowel retraining program to establish a pattern of regular bowel movements. Excess use of any laxative may lead to many complications. In case of any serious side effects, like excessive thirst, skin rashes, vomiting, breathing trouble, difficulty swallowing etc. seek immediate medical attention.

Suppositories

Suppositories are solid or semisolid pellets introduced into the anus to stimulate bowel action or administer medication, i.e. to soothe haemorrhoids or anal itching.

The most commonly used suppositories are; Dulcolax, Glyceriine.

Enemas

Enemas are a small or large amounts of fluid introduced into the lower rectum stimulating bowel action. Fleet enema (most commonly used type) is a saline laxative enema. It works by pulling water from the body into the bowel, which helps to soften the stool and cause a bowel movement.

Enemas should not be given if you are on a sodium-restricted diet or have a history of stomach or bowel problems.

DIARRHOEA

Diarrhoea can have a profound effect both mentally and physically on a person. Severe and prolonged episodes can cause:

- Dehydration
- Anorexia and malnutrition
- Pain
- Anal and skin breakdown
- Sleep disturbance
- Isolation and depression.

Sudden onset or acute diarrhoea

The most common cause of acute diarrhoea is infection-viral, bacterial, and parasitic. Bacteria also can cause acute food poisoning. Another important cause of acute diarrhoea is starting a new medication.

Chronic Diarrhoea

Chronic diarrhoea generally lasts longer than 2 weeks and its causes include:
The most common causes of chronic diarrhoea are:

- Irritable Bowel Syndrome
- Cancer of the colon
- Severe constipation.

The cause of the diarrhoea must be established, this will determine the management of the problem.

Management of Diarrhoea should be focused on resolving the cause and providing physical and psychological support and preventing or correcting dehydration. Most cases of diarrhoea will resolve once the cause is established.

- Acute diarrhoea generally requires rehydration and treatment of symptoms.
- Chronic diarrhoea is usually controlled by diet, life style and medication changes.

It is important that privacy, easy access to clean toilet and washing facilities are provided. To prevent skin breakdown washing the perineal area with warm soapy water is recommended.

All episodes of acute diarrhoea must be considered potentially infectious and universal precautions (hand washing, use of gloves and aprons for single use only, safe disposal) must be adopted to prevent further outbreaks.

The Neurogenic Bowel

A spinal cord injury (SCI) may interrupt nerve pathways from the brain to the gastrointestinal or “GI” system. Neurogenic (noor-oh-JEN-ik) bowel is a condition that happens when the brain and nervous system cannot control bowel functions after a SCI

After SCI, the nerves in the bowel are not able to communicate messages that the bowel is full and that it is time to go to the toilet. There may also be no control over the rectum (the muscle that controls when you have a bowel movement).

The degree of loss will depend on the level and extent of the spinal injury.

With injury above T12, the bowel will continue to empty when stimulated, but there will be reduced or no control. There will also be no message telling that the bowel is full. The muscle that controls the opening and closing of the anus stays tight. When the bowel gets full it will empty automatically. This is called an upper motor neuron type bowel or reflexic hypertonic bowel.

With injury below T12 the bowel will not completely empty even when stimulated. The condition will be lower motor neuron type bowel or flaccid hypotonic bowel. With incomplete or around T12 injury, there may be a mixed upper and lower motor neuron type functioning.

A regular bowel management program will help to ensure that the service user will not experience bowel accidents or impaction. The program can include regular timing, good diet, exercise, proper fluid intake, and the use of laxatives and rectal stimulants.

Autonomic Dysreflexia (AD)

All staff need to identify if the service user is affected by autonomic dysreflexia. Autonomic dysreflexia occurs at injury levels above T-6. It can develop suddenly and is potentially life threatening and is considered a medical emergency. If a person living in a Cheshire Service is affected by autonomic dysreflexia it is necessary that all community services (GP, PHN, Local ambulance, local A&E) are fully briefed, aware of the condition, and have appropriate preparations in case of an emergency.

Definition: AD occurs when an irritating stimulus is introduced to the body below the level of spinal cord injury, such as an overfull bladder, poor bowel care or skin problems. The most common cause seems to be overfilling of the bladder. This could be due to a blockage in the urinary drainage device, bladder infection (cystitis), inadequate bladder emptying, bladder spasms, or possibly stones in the bladder.

Digital removal of faeces (DRF)/Manual Evacuation

Digital removal of faeces is not a procedure that is carried out regularly but in some cases our service users require this procedure. Aperients are given the night before and suppositories/ enema is given at least an hour prior to the procedure in an effort to promote rectal stimulation. Also a light meal and or a warm drink is also recommended to trigger bowel movement. Refer to the guidelines on Digital stimulation and manual evacuation for details of this intervention. **(CLSP31)**

Peristeen Anal Irrigation

Peristeen Anal Irrigation is for people who suffer from faecal incontinence, chronic constipation or have to spend a long time on bowel management procedures. It can be used by people who have neurological disorders such as spinal cord injury, spina bifida, multiple sclerosis, Parkinson's disease, chronic constipation, including bloating .prolonged evacuation difficulties and chronic faecal incontinence. Used on a regular basis, anal irrigation can help

prevent constipation and faecal incontinence. An anal irrigation system will usually consist of a control unit with a pump, a water bag and a rectal catheter.

Service users who use anal irrigation need to be able to sit upright over a toilet, shower chair or commode, the process can be self administer or administered in part or completely by an appropriately trained carer

Anal Irrigation must be supervised and monitored by a Cheshire nurse /PHN, Continence Promotion Unit /Colplast Nurse Specialist

Anal irrigation procedure should always be carried out with care. Bowel perforation is an extremely rare, but serious and potentially lethal complication to anal irrigation and will require immediate admission to hospital, often requiring surgery.

Before starting Peristeen Anal Irrigation, Coloplast instruct that service users should undergo a medical evaluation by a doctor with appropriate expertise to ensure that they have no conditions that preclude its use or require further investigation.

Peristeen Anal Irrigation must not be used in the following situations:

- Known obstruction of the large bowel due to strictures or tumours.
- Acute inflammatory bowel disease/Diverticulitis

Ensure that service users (and where appropriate carers) have received comprehensive training and are competent in the use of the system before using it unsupervised.

Ensure that all involved in management of Peristeen are aware of the risk of bowel perforation, how to recognise the symptoms and actions to be taken.

- Severe and sustained abdominal pain or back pain, especially if combined with fever
- Sustained anal bleeding
- Contact G.P./ Accident & Emergency Department

Bowel Training for Care staff

Clinical Practice Policies; CLSP18,29-32

Best Possible Health Continence assessment care plan

- **Cheshire clinical policy CLSP18**

- Care/Support staff who have received instruction may, administer suppositories, perform digital stimulation and digital removal of faeces and manage the care of stomas.
- **Clinical Assessment-** Have a minimum of three Clinical Assessments in relation to each of the standard procedures and guidelines for this area to confirm the trainees' ability to manage each area of bowel and bladder elimination
- 3/more (if required) clinical assessments will occur in the care worker's place of work and will be carried out by a nurse or senior care/support worker who has received instruction, and with the permission of the service user.
- Certification from the training courses will only last 2 years.

Bowel Care Summary

- It is important to maintain a regular bowel habit to achieve bowel control and avoid complications for the service user
- It is important to keep bowel habit compatible with service users daily routine. Good management is a major factor in improving the health and quality of life for the service user. It needs to be holistic, to consider cultural, social, sexual and vocational role of the service user and fits in with their long term routine
- The complications of a poor bowel regime are constipation diarrhoea and impaction.
- The changes that cause accidents are ineffective bowel care, change in lifestyle and diet, incomplete emptying of the bowel, impatience, adding laxatives and medications

BOWEL MANAGEMENT

Do you / service user have a specific bowel management programme?

Documentation Guideline

- Oral Triggers, tea, toast, documented
- Laxative (rectal and oral) documented
- Digital Stimulation Protocol documented
- Bowel care plan reviewed in last 3 months
- Continence Aids/appliances documented
- Service user provided with oral/written information on maintaining healthy bowel and bladder function

STOMA CARE

Definition:

'Stoma' originates from the Greek word meaning 'mouth' or 'opening'. A bowel or urinary stoma is created by bringing a section of the bowel out on to the abdominal wall. This is normally done in cases where the urinary or bowel tract beyond the position of the stoma is no longer viable.

Types of Stoma for Bowel and Bladder Management

Colostomy: This type of stoma is formed from a section of the large bowel, opening from the large intestine to the abdominal wall so faeces bypass the anal canal.

Ileostomy: This is formed from a section of the small bowel, opening from the small intestine to the abdominal wall so faeces bypass the large intestine and the anal canal.

Urostomy: Connection between the urinary tract and abdominal wall leading to a 'urinary conduit' so urine passes straight into a stoma bag and thus bypasses the urethra.

Why is this surgery performed?

- Cancer of the bowel/bladder
- Trauma
- Neurological damage
- Congenital disorders
- Ulcerative colitis
- Crohns disease
- Diverticular disease
- Other factor

Indications for stoma care:

Stoma care is required for the following purposes:

- To collect faeces or urine in an appropriate appliance
- To achieve and maintain service user comfort and security
- To maintain good skin and stoma hygiene

Changes in faeces

There may be changes to the amount and consistency of faeces. With ileostomies, faeces are produced about 4 hours after a main meal, whereas, with a colostomy, faeces are produced the following morning. Ileostomies are associated with increased output. Often service users have to change their diet to control wind and malodour, e.g. that caused by fizzy drinks and fish respectively. Flatus filters are also available.

Leakage of the contents of the stoma bag can occur and can make service users very distressed. Recurrent leakage can lead to skin inflammation from contact.

Stoma appliances and accessories

The majority of appliances on the market are very similar in style, colour and efficiency. The main aim of good stoma care is to provide a safe, reliable appliance that is comfortable, unobtrusive and easy to handle.

Bags are labelled according to the size of the opening that fits around the stoma size. Some are pre-cut others have a template that can be cut to size. In order to protect the skin from waste products the size should fit snugly around the stoma allowing 0.5cm gap from the stoma edge. This prevents adhesive rubbing against the stoma.

APPLIANCES

All appliances come in either:

- ONE-piece (*where the pouch is welded to the flange*) or
- TWO-piece systems (*where the pouch and flange can be separated*)

Colostomy Appliances

If using a one-piece closed pouch, it must be renewed every time the pouch becomes full. This will involve cleaning the stoma and surrounding skin before putting the new pouch on.

In general, colostomy service users will change their pouch once or twice a day. Those using a two-piece product will renew the pouch once or twice a day, leaving the flange (*base plate*) in place, to be changed usually every second or third day.

Illeostomy Appliances

If using a one-piece drainable pouch then the whole appliance will need renewing every 2-3 days. The pouch itself will require emptying 4-6 times a day and possibly once overnight.

Two-piece drainable pouches need renewing approximately every 3-4 days, but will need to be emptied regularly.

Urostomy appliances

With either a one or two-piece system, the appliance would usually stay in place 2-3 days. The pouch itself (depending on oral fluid intake) would need regular emptying.

If overnight drainage is used the catheter bag is emptied down the toilet, the tubing and bag washed through and left to dry so it can be re-used. Overnight drainage bags may last one month in the community. However, it is down to the service user's preference and many patients will change their overnight drainage bag every 3-7 days. The indication for this is that the overnight bags may become discoloured, smell, or become blocked with mucus.

Accessories

The following products should not be used routinely, only as required and following advice from the stoma care nurse.

Stomahesive Paste

This paste is used to fill in creases, creating a more even surface for the appliance to adhere to. It may sting on sore skin as it contains alcohol.

Cohesive Ostomy Seals

Hydrocolloid rings come in two sizes and possess adhesive properties on both sides.

- (a) **Small** - It can be stretched to form a secure seal around the stoma and can be used for extra reinforcement.
- (b) **Large** - It can be stretched or cut to protect a large area of skin, i.e. wounds, fistulae, drain sites and where a wound manager bag may need to be applied if the output is high

Orahesive Powder

Hydrocolloid powder absorbs moisture and protects the skin. The powder itself is quite chalky and must be used sparingly. Too much will prevent the flange from sticking.

Orabase Paste

Hydrocolloid paste mixed with paraffin oil. It is used to protect the stoma edges where there is slight detachment, for ulcers, bleeding mucosa on a stoma, or a sore stoma. For a new stoma, which is dusky, it should be applied immediately to attempt reduction of oedema.

It should not be used under adhesives as this will prevent the appliance adhering to the skin.

Solutions for cleaning the skin and stoma.

The stoma is not a wound and should be regarded as a re-sited anus or urethra. Mild soap and water or water only is sufficient for cleaning the area. Detergents, disinfectants and antiseptics can cause dryness and should not be used.

In some cases adhesive can adhere to the skin when the flange is removed, this can build up and cause irritation. In severe cases an adhesive remover solution can be used. This should not be used on broken skin.

Possible Causes of Sore skin

- Weight gain (weight loss will lead to the stoma getting smaller)

Changes in output

- Changes in medication e.g. antibiotics or chemotherapy
- Changes in diet
- Anxiety
- Gastroenteritis

If the stool becomes loose or watery, if service user is experiencing a change in the consistency of output, this will increase the possibility of it leaking under the adhesive onto the skin and causing soreness.

Small lumps may have appeared around your stoma

Repeated friction from the pouch can make this worse. Granuloma are harmless but can be a nuisance as they bleed readily when touched. This may cause the pouch to leak because, if it is covering the lumps, any moisture from them may cause it to lift and break the seal.

Existing skin disease

If you had a skin disease such as eczema or psoriasis prior to your operation, there is always the chance that it may occur near your stoma, afterwards.

Changes in sensitivity

Even if you have happily used the same stoma product for years, it is not unknown to suddenly become sensitive to it.

Hairy tummies

Gentlemen with hairy tummies may notice small pink pimples around the stoma. This is called folliculitis and is due to the pouch pulling on the tiny hair follicles in the skin. This can be reduced by shaving the skin around the stoma periodically, but not more than once a week. Use a new disposable razor and warm water only when doing this, as shaving creams, hair removing creams and gels can all cause irritation and soreness.



Record in the Best Possible Health Stoma Record and report and record on Daily continuation sheet any adverse changes; loose watery stool/change in consistency, lumps, itchiness, infection or sensitivity to lead clinical person/ line manager/ G.P. Contact Stomatherapy Nurse Specialist, who will be able to advise.

Appendices

Appendix 1: Bowel charts

Bowel Assessment Tool

Service Users Name: _____ **Service:** _____

Please tick relevant box

Comments

How often does your bowel open?	Daily <input type="checkbox"/>	Alt Days <input type="checkbox"/>	3 or more days <input type="checkbox"/>					
How often do you have DRE?	Daily <input type="checkbox"/>	Alt Days <input type="checkbox"/>	3 or more days <input type="checkbox"/>					
How often do you have/use DRS?	Daily <input type="checkbox"/>	Alt Days <input type="checkbox"/>	3 or more days <input type="checkbox"/>					
How often do you have manual evacuation?	Daily <input type="checkbox"/>	Alt Days <input type="checkbox"/>	3 or more days <input type="checkbox"/>					
Type of stool as per BSFS	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>		4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Do you have soiling/staining of underwear?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Never <input type="checkbox"/>					
Do you ever pass stool accidentally?					Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Can certain food/medication cause loose stool?					Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Are you bloated or have abnormal cramps?					Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Any blood, mucus in stool, pain or discomfort on passing stool?					Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Any recent change in bowel habits?				Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Diet and Fluids:

Does daily diet include:	Fibre <input type="checkbox"/>	Vegetables <input type="checkbox"/>	Fruit & Fruit Juice <input type="checkbox"/>
Total Fluid intake per 24 hrs _____	Total Urinary Output per 24 hrs _____		

Skin Assessment:

Healthy <input type="checkbox"/>	Intact <input type="checkbox"/>	Red/Mottled <input type="checkbox"/>	Excoriated <input type="checkbox"/>	Rash <input type="checkbox"/>	Pressure Wound <input type="checkbox"/>
Waterlow Score: _____					

Bowel Management Plan:

Early morning stimulants	Hot Water <input type="checkbox"/>	Tea <input type="checkbox"/>	Coffee <input type="checkbox"/>	Fruit Juice <input type="checkbox"/>	Toast <input type="checkbox"/>
Oral Laxatives	Type: _____		Dosage: _____		
	Times Admin: _____		Recommendations: _____		
Rectal Suppository	Type: _____		Amount Prescribed: _____		
	Times Admin: _____		Recommendations: _____		
Digital Rectal Stimulation	Number of stimulation: _____		Rest Periods: _____		
	Coughing or other assistive mechanisms: _____				
Manual Evacuations	Daily <input type="checkbox"/>	Alt days <input type="checkbox"/>	3 or more days <input type="checkbox"/>		
	Recommendations: _____				
Diet & Fluids	Recommendations: _____				
Disposable Products, other aids or appliances	Recommendations: _____				
	Product type: _____	Code: _____	Size: _____	No pr. 24 hour: _____	
	Appliances: _____				

Neurogenic Bowel Care Plan Record

Date	Aperients	Date	Rectal medication	Breakfast	Digital stimulation	Bristol stool chart	signature
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							

Appendix 2.

What does the continence advisory nurse do?

There is usually open access to continence promotion clinics and details can be found by contacting your local HSE area. People can also be referred by GPs, practice nurses or public health nurses.

The services are for people who have all types of incontinence.

At the clinic a detailed assessment is carried out. This will include questions about the nature of a service user's problem and the symptoms. A urinalysis will be carried out and bowel history if appropriate.

Other issues will be reviewed such previous surgery, underlying medical condition, current medication, emotional aspects, and mobility problems.

Where appropriate, the continence nurse may refer for specialist advice. Urologists, gynaecologists, physiotherapists, dietitians and occupational therapists all have a role in treating various types of incontinence.

The continence service can give guidance and advice on issues such as:

- Readjusting fluid intake
- Bladder retraining
- Pelvic floor exercises
- Individualised toileting programmes
- Bowel programmes
- Self catheterization
- Catheter management
- Medication review
- Environment changes
- Counselling and advice
- Electrotherapy

What does the Stomatherapy Nurse Specialist do?

The Stomatherapy Nurse Specialist can give guidance and advice on issues such as: education, support and follow-up care to people who have had surgery to create a stoma. Where appropriate, the Stoma therapy Nurse may refer for specialist advice to colorectal specialists and dietitians

Appendix 3

Multiple Sclerosis (MS) and Incontinence

Approximately, 3 in 4 people with MS will suffer with continence problems. Bladder and bowel problems can come and go and can be more pronounced at some times than at other times.

If a bladder or bowel problem is caused by nerve damage which results from MS, then the dysfunction will be called 'neuropathic' or 'neurogenic'. This means that there is damage to the nerves which are meant to control the way that ones bladder and bowel work.

Incontinence can also develop as a 'secondary symptom' which means that incontinence can be caused by another symptom and not directly by MS nerve damage. These symptoms can include:

- Getting to a toilet in time. MS makes moving about difficult which can cause problems in getting to a toilet. A visit to an occupational therapist may be able to help with these problems.
- Restricted physical activity can often lead to constipation and poor muscle tone which can then lead to bladder and bowel problems. A physiotherapist could help and set an exercise programme which could help to alleviate problems.

The continence problem could be completely unrelated to the MS and be a separate condition which one will need to investigate.

Spina Bifida

- 2/3 of adults have a satisfactory social continence pattern.
- Regularity is most important.
 - Timed evacuation
 - Same diet
 - Same exercise pattern
- Not related to the level of the spina bifida.

Appendix 4.

Autonomic dysreflexia (AD)

All staff need to identify if the service user is affected by autonomic dysreflexia when caring for people with spinal cord injuries. Autonomic dysreflexia, occurs at injury levels above T-6.(mid chest) It can develop suddenly and is potentially life threatening and is considered a medical emergency.

Definition;

AD occurs when an irritating stimulus is introduced to the body below the level of spinal cord injury, such as an overfull bladder, poor bowel care or skin problems. The most common cause seems to be overfilling of the bladder. This could be due to a blockage in the urinary drainage device, bladder infection (cystitis), inadequate bladder emptying, bladder spasms, or possibly stones in the bladder

Signs or Symptoms of AD are:

- high blood pressure
- pounding headache
- flushed face
- red blotching on chest
- sweating above level of injury
- goose bumps
- nausea
- feeling anxious

Staff can help prevent AD by:

- Following a regular bowel program
- Checking skin daily
- Wearing loose fitting clothing; and checking for painful stimuli and removing.
-

If any rectal bleeding or signs of distress or autonomic dysreflexia occurs, stop the procedure immediately, call A& E, contact the senior members of staff

If signs of distress or autonomic dysreflexia occurs

- Stop the digital stimulation, manual evacuation
- Sit upright as this will bring blood pressure down slightly
- Follow guidelines
- Contact Accident & Emergency Department

- On arrival at hospital a person should be specifically coded for immediate attention
- **Remember – Carry a Card!** Always remind service user to carry a card which identifies AD .Give this to staff in an Emergency Room or the doctor's office if the service user has an AD attack.

References:

- Mallett, J. & Dougherty, L. (2000). *The Royal Marsden Hospital Manual of Clinical Nursing Procedures*. Blackwell Publishing, Oxford.
- Nicol, M., Bavin, C., Bedford-Turner, S., Cronin, P. & Rawlings-Anderson, K. (2004). *Essential Nursing Skills*. Mosby, United Kingdom.
- Robertson, B. & O'Kell, S. (1995). *Study Guide for Health and Social care Support Workers*. First Class Books Pub., Bristol.
- www.constipationadvice.ie
- www.ehow.com › ... › [Family Health](#) › [General Family Health](#)
- Spinal Injuries Ireland, National Rehabilitation Hospital, Rochestown Ave, Dún Laoghaire, Co. Dublin, Ireland
- [Stoma care guidelines for nurses caring for patients with a stoma](#) Royal Free Hampstead, London NHS 2010
- Nelson H. Diseases of the rectum and anus. In: Goldman L, Ausiello D, eds. *Cecil Medicine*. 23rd ed. Philadelphia, Pa: Saunders Elsevier; 2007: chap 148.
- *Health Guide for Adults Living with Spina Bifida* Optimizing Your Health in Adulthood Thomas S. Webb, MD, MSc Spina Bifida Association
- British Skin Foundation, Salts Healthcare *Guidelines for people who have Colostomies*
- *Stoma care guidelines for nurses caring for patients with a stoma* 2010Royal Free Hampstead, London NHS.
- *Guidelines for Management of Neurogenic Bowel Dysfunction after Spinal Cord Injury* 2009 Spinal Cord Injury Centres of the United Kingdom and Ireland.