| Person’s Name | Date of Birth | ProviderOne Number |
| --- | --- | --- |
|  |  Developmental Disabilities Administration (DDA) **Bowel Protocol** **You do not need permission to call 911.**Date of Protocol Creation: |
| Call 911 and **START FIRST AID** as trained if: Possible signs of bowel-related emergency1. The person is not breathing or is blue / gray in color.
2. The person is having difficulties breathing or making abnormal noises while breathing.
3. The person appears ill; and you are concerned about their immediate health and safety.
4. The person has not had a bowel movement in  days.
5. The person vomits material which smells like stool or looks like coffee grounds or dark jelly.
6. The person has a temperature greater than  or less than .
7. The person has unrelieved abdominal discomfort.
8. Other:

**After 911 has been notified, follow instructions from the dispatcher. Notify the dispatcher if there is a POLST DNR/I in place.**After calling 911 and stabilizing the person:* Contact your supervisor.
* Document per agency protocol in the person’s chart.
 |
|  |
| **General Signs and Symptoms of Constipation** |
| **People who are experiencing constipation or a bowel impaction may still have small bowel movements. Please take action to evaluate and treat a person who is experiencing ANY of the General Signs and Symptoms of Constipation.*** Hard, small, dry stool.
* Extra time in the bathroom with little to no bowel movement.
* Straining to produce a bowel movement.
* Abdominal bloating.
* Stomach pain / discomfort.
* Declining food or fluids.
* Vomiting
* No bowel movement for several days.
 |
| **Get to Know Me:** |
| How often I typically have bowel movements:  What signs I show when I’m constipated: I require the following assistance when toileting: [ ]  Independent [ ]  Some Assistance [ ]  Total AssistanceComments: I have a toileting schedule: [ ]  Yes [ ]  NoIf yes, schedule:  |
| I take the following medications **to help with bowel movements** (per MAR):[ ]  None |
| **Medication Name** | **Medication Dose** | **Medication Frequency** |
|  |  |  |
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|  |  |  |
| I take the following medications **as needed (PRN)** for constipation (per MAR):[ ]  None |
| **Medication Name** | **Medication Dose** | **Medication Frequency** |
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| I have a Nurse Delegator who trains staff on medication administration: [ ]  Yes [ ]  No |
| Delegator’s Name | Delegator’s Phone Number |
| Notify my Nurse Delegator when I (follow Nurse Delegation Instructions and Task form): Notify my Heath Care Provider when I:  |
| Health Care Provider’s Name | Phone Number | Fax Number |
| **Preventing Constipation** |
| Administer medications as prescribed (please review the MAR for instructions). Document bowel movements each shift. Dietary recommendation: Fiber Intake Recommendation: Fluid Goal: Exercise / Activity: **Contact my Nurse Delegator or Health Care Provider with my medication related questions.**  |
| Additional Information |
| Plan Completed by: | Date Plan Completed |
| Health Care Provider’s Signature | Date Signed |
|  |  |
| Health Care Provider’s Name | Phone |
| **Date of last review (enter signature and date):** |
|  |  |  |
|  |  |  |
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| **Bowel Tracking Sheet** |
| Month:  | Day Shift | Evening Shift | Night Shift | PRN Medications Administered | Comments (e.g., consistency and color and PRN results) | Staff Initial |
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| 31 |  |  |  |  |  |  |
| Legion: Small (S) – less than four inches; Medium (M) – between 4 – 8 inches in length; Large (L) – greater than eight inches |