BOWEL MANAGEMENT PLAN

Sample

Name: DOB: Date:

Bowel Pattern and **Management**

DAY 1

Give routine aperient

↓

Bowels open = remains Day 1

Bowels <u>not</u> open

DAY 2

Give routine aperient

↓

Bowels open = return to Day 1

Bowels <u>not</u> open

DAY 3

Give routine aperient

↓

Bowels open = return to Day 1

Bowels <u>not</u> open

↓

Use enema OR suppository

as ordered *

↓

Bowels open = return to Day 1

Bowels <u>not</u> open

DAY 4

Give routine aperient

↓

Bowels open = return to Day 1

Bowels <u>not</u> open

↓

<u>REPORT to Manager, RN or HST</u>

All bowel *results* must be recorded on *Bowel Chart* DAILY
All *interventions* must be recorded on *Medication sign-off* sheet
If client is having *diarrhoea* or *frequent bowel motions:*
RECORD on client's Bowel Chart + REPORT to Manager or RN
NEVER withhold routine aperient unless directed by Manager or RN