**The Salvation Army – William Booth Special Care Home**

**Gastrointestinal Policies and Procedures**

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# Tube Feedings

**POLICY:**

This policy is written to provide direction regarding tube feeding - the administration of tube feeding, occlusions, medications, and site care.

WBSCH will follow RQHR Nursing Procedure (CODE T.5) Tube Feeding (attached 13 pages).

1. **TUBE FEEDING:**

**NURSING ALERT:**

|  |
| --- |
| * This policy is written for implementation with **Adult** clients
* The head of bed (HOB) should be elevated a minimum of 30 – 45 degrees during feeding and for one hour following feed.
* It is suggested to keep the HOB slightly elevated at all times when not doing care as the stomach contains digestive juices that can be regurgitated.
* **Feeding tubes** must be **flushed** with a minimum of 25 mL water when feed is commenced, interrupted, completed, before and after medications or residuals, or every 4 hours when feeds are continuous.
* Use **tap water** for flushing of tubes in LTC
* All **flushes** should be done using a vigorous **push pause technique** creating a turbulent flow.
* Following each intermittent feed: **flush bags and tubing** with water.
* **Change tubing, solution bags and syringe a minimum of once weekly.**
* Enteral **formula must not hang at room temperature for more than 6 hours.** Open cans must be labeled, covered, refrigerated and used within 24 hours. Warm formula to room temperature prior to feeding.
* **Closed systems**, where the bottle of formula attaches directly to the pump tubing, may hang according to manufacturer recommended instructions.
* **Do not add new formula** to bag with formula currently infusing.
* **Do not add medication** directly to enteral feed.
* **Mouth care** and stimulation appropriate for clients must be done every 2 – 4 hours while awake.
* If tube occlusion occurs do not force irrigation.
 |

**TUBE FEEDING EQUIPMENT:**

* Enteral formula as ordered
* PPE (non-sterile gloves)
* Enteral infusion pump (as required)
* Tubing and bag
* 60 mL luer catheter tip syringe
* Warm tap water (room temperature)
* Wound ruler or measuring tape

**TUBE FEEDING PROCEDURE:**

1. **Check physician’s order** for type, amount and rate of feeding (documented in MAR).
2. **Wash hands** thoroughly
3. **Don PPE**
4. **Unclip stat-lok (**stabilization device)
5. **Confirm correct placement** by observing length of PEG / MIC and compare to length documented in care plan
6. **Check residual amount:**
* Measure and document gastric residuals every 4 hours **until goal volume tolerated for 24 hours post initiation of new feeds or when rate or volume orders are changed.**
* Check residual **PRN** and when client exhibits signs of gastric intolerance, for mature gastrostomy feeds
* **NOTE**: signs of gastric intolerance include, but are not limited to increased abdominal girth / abdominal distension, nausea, vomiting, reflux
* **Adults (Intermittent feeds):**
	+ If residual is less than 250 mL, re-instill and continue with scheduled feeding
	+ If residual is more than 250 mL, do not re-instill. Hold feeds and recheck in 1 hour. If residual is still more than 250 mL, do not re-instill. Notify physician and dietician.
* **Adults (Continuous feeds):**
	+ If residual is less than 250 mL, continue feeding if no other signs of intolerance.
	+ If residual is more than 250 mL, re-instill to a maximum of 400 mL and continue feeding
	+ Repeat residual in 2 hours
	+ If second residual is less than 250 mL continue feeding
	+ If second residual is more than 250 mL, do not re-instill. Hold feeds. Notify physician and dietician.
1. **Flush** using a **push pause technique** with a minimum of 25 mL of tap water (physician and or dietician will identify the amount of water)
	* **Flushing** before and after checking **residuals** is imperative as gastric acids will bind with protein in formula and may clog the tube
2. **Set up the equipment** per manufacturer’s instructions
3. **Prime tubing** with enteral formula (to reduce air in stomach)
4. **Connect** to the adapter
5. **Administer feed** via gravity or pump at prescribed rate and volume
6. **Flush** using a push pause technique
7. **Document** feed amount and water flush amount
8. **OCCLUSION:**

**NURSING ALERT:**

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| --- |
| * If tube occlusion occurs do not force irrigation.
* Check to make sure the tubing is not kinked
* Use a 60 mL luer catheter tip syringe as smaller syringe may rupture feeding tube (smaller than 35 mL catheter tip syringe)
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**OCCLUSION EQUIPMENT:**

* PPE (non-sterile gloves)
* 60 mL luer catheter tip syringe
* Warm tap water (room temperature)
* Ordered medication

**OCCLUSION PROCEDURE:**

1. Wash hands thoroughly
2. Don PPE
3. Attach empty 60 mL luer catheter tip syringe to feeding tube and gently pull back on plunger
4. Attempt to irrigate feeding tube with 50 mL warm tap water using a gentle back and forth motion
5. Obtain physician’s order for a pancreatic enzyme mixture if above unsuccessful
6. Mix pancreatic enzymes in medication cup with 50 mL’s of warm tap water until dissolved
7. Draw dissolved pancreatic enzymes up into 60 mL luer catheter tip syringe
	* **Note:** **Recommended adult mixture: 1 pancrealipase capsule (Cotazym) and Sodium bicarbonate (500mg tablet)**
8. Infuse dissolved pancreatic enzymes gently into feeding tube and leave in 5 minutes.
9. Attempt to irrigate feeding tube again, as in step 4 (Attempt to irrigate feeding tube with 50 mL warm tap water using a gentle back and forth motion)
10. Repeat steps 5 and 6 if occlusion persists
11. Notify physician if tube occlusion persists
12. Document
13. **MEDICATION(S):**

**NURSING ALERT**

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| --- |
| * Use medications in liquid form whenever possible
* If pills or capsules must be used, crush to a fine powder and dissolve in warm water prior to administering
* DO NOT crush extended release, enteric coated and sublingual or buccal forms of medication
* Contact pharmacy for additional medication concerns
* Most liquid medications may be diluted with water before administration to minimize development of diarrhea and gastric irritation
* Some medications will be rendered inactive when administered in conjunction with enteral feeding (see attached RQHR policy Appendix 1, page 12 and 13)
* Consult dietician for adjustment of feeding regimes PRN
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**MEDICATION EQUIPMENT:**

* PPE
* Soap and water
* Warm tap water
* 6 mL leur tip syringe

**MEDICATION PROCEDURE:**

1. Flush feeding tube using vigorous push pause technique with 25 mL water before medication administration
2. Administer dissolve diluted medication via syringe into feeding tube / medication port
3. Administer each medication separately to prevent drug interactions
4. Flush feeding tube using vigorous push pause technique with 25 mL water following EACH medication administration
5. Document
6. **SITE CARE:**

**SITE CARE EQUIPMENT:**

* PPE
* Soap and water
* Dressing (as necessary)

**SITE CARE PROCEDURE:**

1. Wash hands
2. Don PPE
3. At each feeding, inspect skin surrounding tubing for redness, drainage and inflammation
4. Cleanse site at least daily with soap and warm water
5. Be sure to clean under the ring of the MIC or Button gastrostomy tube
6. Rinse and dry will to avoid fungal infections
7. Apply dressing to site PRN (DO NOT tape or dress well healed stoma)
8. Rotate mature PEG tube or bolster ¼ turn daily to prevent irritation and pressure sores (DO NOT rotate PEJ tube)
9. **ORAL CARE**

**ORAL CARE PROCEDURE:**

1. Teeth, gums and tongue must be brushed BID
2. LIP GLOSS, Vaseline or moisturizer should be used to prevent dry lips (DO NOT use Vaseline if on Oxygen)
3. Monitor for cracks at corners of the mouth

**REFERENCE:**

* RQHR Nursing Procedure CODE T.5 TUBE FEEDING

Initial Implementation Date: June 22/98

Review Date: June 6/00 / June 4/03 / August 31/05 / December 1/13 / April 22/15

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Replacement Of A Displaced PEG Tube With Foley Catheter

**POLICY**:

This policy is written to provide direction to the RN / RPN nursing staff to maintain the stoma tract when the permanent feeding tube falls out.

At WBSCH, this is a special nursing procedure that can only be completed by an RN / RPN certified in the procedure (certified at WBSCH).

**NURSING ALERT**

|  |
| --- |
| * WBSCH will follow RQHR Nursing Procedure (Code T.5.1) Percutaneous Gastrostomy Tube Replacement (attached 5 pages)
* At WBSCH, this is a **special nursing procedure** that can only be completed by an RN / RPN certified in the procedure (certified at WBSCH)
* A **physician’s order** is necessary for the temporary insertion of a Foley catheter into the gastronomy site
	+ Insert same size Foley CATHETER or next size smaller.
* A **physician’s order** is necessary for the continuation of tube feeding protocol, following temporary insertion of Foley catheter.
	+ Physician either checks the placement of the catheter or gives an order to continue with Tube Feeding protocol.
	+ Hold nutritional tube feeds until tube placement assessed by physician or order given to continue with Tube Feeding protocol. .
* Sterile technique is required when performing this procedure.
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**EQUIPMENT**:

* PPE (sterile Procedure)
* Soap and water, washcloth, towel
* Non-sterile gloves
* Sterile urinary catheter insertion kit
	+ Sterile gloves
	+ Water soluble lubricant
	+ Pre-filled 10cc Luer-Lok syringe with sterile water
* Sterile urinary catheter (FOLEY) of appropriate type and size.
	+ Foley balloon should be no larger than 10cc (30cc balloon is too large)
* Urinary catheter plug
* 60 ml catheter tip syringe
* Litmus paper (available from Hospice medical supplies)
* Wound ruler or measuring tape
* Stat-Lok for stabilization of Foley catheter tube
* Protective cream for stoma care, as necessary

**PROCEDURE:**

1. Notify physician re: occlusion or accidental displacement
2. Obtain physician’s order to replace displaced PEG tube with a Foley catheter or to transfer to Acute care for replacement
3. Notify Health Care Manager on-call (if after hours / weekend)
4. Don PPE as appropriate.
5. Assemble equipment.
6. Explain procedure to client.
7. Position client supine.
8. Clean any spilled gastric fluids with warm, soapy water. Rinse. Dry.
9. Don sterile gloves.
10. Check the urinary catheter prior to placement
* Check the catheter balloon by filling it with sterile water (amount according to manufacturer’s instructions).
* Foley balloon should be no larger than **10cc** as 30cc is too large
* **NOTE: Silicone material has a tendency to adhere to itself. If necessary, roll the inflated balloon gently between the thumb and index finger to achieve symmetry.**
* Deflate the catheter balloon after check.

1. Lubricate the tip of the new catheter with water-soluble lubricant.
* **NOTE: Do not use oil or petroleum jelly.**
1. Gently guide the catheter through the stoma and into the stomach
* Hold the catheter at a 90 degree angle to the abdomen.
* Insert the catheter until the entire balloon area has passed through the tract.
* If resistance is met, completely remove the catheter and try again.
1. Inflate the catheter balloon with the appropriate amount of sterile water.
* **NOTE: Never fill the catheter balloon with more than 10cc sterile water**
* **NOTE: Never fill the catheter balloon with air or saline.**

1. Grasp the body of the catheter and withdraw it until slight tension is felt from the balloon coming up against the stomach wall.
* **NOTE: Do not apply excessive tension.**
1. Confirm correct placement by the following method:
* Aspirate for stomach contents and test pH level. A pH level of <4 is expected.
* **NOTE: Deflate catheter balloon and repeat steps 10-13, if placement incorrect.**
1. Secure the catheter as appropriate (Stat-Lok).
* Apply the end cap to the catheter to ensure the system is closed to maintain sterility of the system
1. Wipe any fluid or lubricant from the catheter and stoma.

1. Apply protective creams if prescribed.

1. Apply dressing to site PRN. **DO NOT** tape or dress a well-healed stoma.
2. Document:
* Record type and size of Foley catheter
* Record the amount of sterile water instilled into catheter balloon (never fill the catheter balloon with more than 10cc sterile water)
* Record the external length of the catheter from stoma to end of the catheter.
* Record the date, time and name of Physician notified of PEG tube dislodgement.
* Record the date, time and name of Physician who came to check placement or gave order to continue with Tube Feeding protocol.

**REFERENCE:**

**RQHR Nursing Procedure T.5.1** Percutaneous Gastrostomy Tube Replacement

Initial Implementation Date: June 6/98

Review Date: March 17/15

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Digital Bowel Care

**POLICY:**

This policy is written to provide direction to staff regarding the manual check for and / or the manual removal of stool from the rectum. Digital bowel care can also be used to stimulate peristalsis (defecation).

Digital bowel care (dis-impaction) is the responsibility of the RN / RPN / LPN.

Digital bowel care includes:

* Manually checking for stool in the rectum
* Digital stimulation - relaxation of the anal sphincter by gently rotating a finger against the anal sphincter wall
* Digital dis-impaction - manually breaking up hard stool into smaller fragments for easier removal
* Digital evacuation - manually removing stool from the rectum.

**EQUIPMENT:**

* Disposable gloves.
* Water soluble lubricant.
* Incontinent pad(s).
* Small plastic garbage bag.
* Soap, water and disposable washcloths.

**PROCEDURE:**

* Explain procedure to the resident and provide privacy. Check the **Care plan** for the resident’s bowel care routine.
* Position resident on left side with upper knee flexed (unless contraindicated for medical/orthopedic reasons).
* Set up equipment: incontinent pads under the resident and gloves on.
* Place lubricant, garbage bag and washcloth within reach.
* Lubricate index finger of gloved dominant hand.
* Lift resident’s upper buttock with non-dominant hand and instruct resident to take several deep breaths through the mouth. This relaxes the anal sphincter and lessens anxiety.
* Gently insert index finger beyond the anal sphincter to assess for stool in the lower bowel.
* Gently evacuate the lower bowel if stool is present by rotating the finger around the stool to dislodge it and break it into small fragments which can be pulled out by the index finger using a slight scooping motion.
* Remove fragments separately and allow resident to rest periodically.
* **NOTE: It may be necessary to gently insert 2 fingers to crush the fecal mass using a scissors-like motion.**
* Before removing the finger, gently stimulate the anal sphincter 2-3 times by rotating the finger. This stimulates peristalsis which helps to complete evacuation.
* **STOP** procedure immediately if bleeding**, pain, dizziness or rapid heart** rate occurs.
* Observe stool for color, consistency, amount, presence of blood, pus, mucus and resident’s tolerance of procedure.
* Wash rectal area and leave resident comfortable.

Initial Implementation Date: Sept 5/99

Review Date: November 15/16

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Administering A Rectal Suppository

**POLICY:**

This policy is written to provide direction to WBSCH health care staff regarding the insertion of a rectal suppository (laxative) into the rectum.

The task of insertion of a rectal suppository (laxative) is DELEGATED to CCAs that have been certified to perform the task of inserting a rectal suppository at WBSCH. Certification requires the CCA to successfully complete a QUIZ and successfully complete a return demonstration.

The delegating Care Manager / designate will assume responsibility for the observing the return demonstration and documentation of completion.

Digital bowel care (dis-impaction) is the responsibility of the RN / RPN / LPN.

**NOTE: A Physician’s order is required prior to the administration of a laxative suppository.**

**EQUIPMENT:**

* Laxative suppository (Bisacodyl)
* Water soluble lubricant
* Disposable gloves
* Eye protection
* Blue pad(s)
* Bedpan, commode or toilet (as applicable).
* Soap, water and disposable washcloths.

**PROCEDURE:**

1. **Wash hands** thoroughly with soap and water or alcohol based hand sanitizer.
2. Verify the task with the nurse.
3. Check when the resident’s last bowel movement was documented (Point of Care).
4. Gather necessary equipment (bed protection if needed, gloves, eye protection, suppository, and lubricant) and assemble at the bedside.
5. Check the “Nine R’s”

Right resident

Right medication

Right dose

Right route

Right day

Right time

Right reason

Right expiry date

Right documentation

1. Explain the task to the resident.
2. Assist the resident to lie on their left side (if possible) with their lower leg straightened out and their right upper leg bent forward toward their stomach.
3. Put on gloves.
4. **Put** **safety glasses on when required**
5. If the suppository is soft, hold it under cool water to harden it before removing the wrapper.
6. Remove the suppository wrapper if present.
7. Lubricate the suppository tip with a water-soluble lubricant such as K-Y Jelly, **not** petroleum jelly (Vaseline).
8. Lift upper buttock to expose the anal area.
9. Insert the suppository, pointed end first, with your finger until it passes the muscular sphincter of the rectum, about 1-1½ inch in adults. If not inserted past this sphincter, the suppository may pop out. Insert the suppository against the side of the rectum. Do not push the suppository into stool.
10. Have the resident squeeze buttocks together for a few seconds. If the resident unable the caregiver should hold the tissue of the buttocks closed.
11. Have the resident remain lying down for about 20-30 minutes to allow the suppository to dissolve.
12. Remove gloves.
13. Discard used materials and **wash hands** thoroughly.
14. Sign the appropriate Treatment Medication Assistance Record.
15. Document results in Point of Care (POC).
16. Ensure the resident is safe and comfortable (nurse call system within resident reach, side rails as required).

Reference: WBSCH Care Basics (delegation) for CCAs (2015)

Initial Implementation Date: Sept 5/99

Review Date: July 26/01 / May 3/03 / January 31/06 / December 1/13 /September/15

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Administering A Fleet Enema

**POLICY:**

This policy is written to provide direction to staff regarding the introduction of fluid (fleet enema) into the rectum which stimulates peristalsis and evacuation; by causing nerve stimulation and mechanical distention of the colon.

A fleet enema is a small volume enema and may be used with a rectal tube which gets fluid to a higher level and provides added stimulation.

Only an RN / RPN / LPN is allowed to perform this procedure.

**NOTE: A physician’s order is required prior to the administration of a fleet enema.**

**EQUIPMENT:**

1. Fleet enema
2. rectal tube
3. Disposable gloves
4. Water soluble lubricant
5. Incontinent pad(s) / product
6. Small plastic garbage bags
7. Bedpan/commode (if applicable).
8. Soap, water and disposable washcloths

**PROCEDURE:**

* Explain procedure to resident and ensure privacy. Check the care plan for the resident’s bowel care routine.
* Position resident on the left side with upper knee flexed (unless contraindicated for medical / orthopedic reasons).
* Set up equipment, drape resident to ensure privacy and put incontinent pads under buttocks.
* Put on gloves.
* Attach rectal tube (if used), to Fleet enema and lubricate the end. Expel **a**ir from tubing by squeezing the enema until fluid comes to the end of the rectal tube.
* Lift resident’s upper buttock with non-dominant hand and instruct resident to take deep breaths through their mouth. This relaxes anal sphincter, decreases discomfort and lessens anxiety.
* Guide the rectal tube into the rectum in a direction towards the umbilicus (a rectal tube may be inserted up to approximately 8”or 20 cm.).
* Squeeze the fleet enema until it is empty and instruct client to try and hold fluid as long as possible.
* Stop the procedure immediately if bleeding, pain, dizziness or unusual side effects occur and notify Team Leader (RN/RPN).
* After the bowel evacuation is complete, observe stool for color, consistency, amount, presence of blood, pus or mucous and resident’s tolerance of procedure.
* Wash rectal area and ensure resident is comfortable.

Initial Implementation Date: Sept 5/99

Review Date: July 26/01 / May 3/03 / January 31/06 / December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Colostomy Change

**POLICY:**

This policy is written to provide direction to staff regarding the consistent method to be used when changing a colostomy bag and to ensure infection control standards.

The changing of the colostomy bag and flange is the responsibility of the RN / RPN / LPN.

The emptying of the colostomy bag on a daily basis may be designated to the CCA.

**EQUIPMENT:**

1. Disposable washcloths
2. warm tap water
3. garbage bag
4. paste
5. colostomy bag
6. flange
7. scissors
8. pen
9. pattern (if used)

**PROCEDURE:**

1. Cut the flange to the pattern size that fits the base of stoma.
2. Smooth the cut flange / hole edge with your fingers.
3. Remove the paper backing.
4. Apply a ring of paste to the cut flange / hole edge
5. Remove the backing from the adhesive area. Set flange aside.
6. Remove soiled colostomy bag and flange. Dispose of in garbage. (save the clamp

 closure if applicable).

1. Cleanse the skin and stoma with water. Pat skin completely dry.
2. Apply flange to skin, center over the stoma. Press.
3. Snap colostomy bag onto flange ring.
4. Close bottom of pouch (with clamp closure/if applicable)
5. One flange and two pouches should be used per week, if using drainable pouches.
6. Pouch may be rinsed out with plain warm water while intact (open end pouch).
7. When washing **reusable colostomy bags**, lukewarm water and a few drops of liquid dish detergent work well. Be sure to rinse thoroughly - hang to air dry.

SOURCE:

RQHR Ostomy and Wound Care Centre / Pasqua Hospital:  **A GUIDE TO OSTOMY SURGERY AND CARE**

Lippencott Manual of Nursing Procedures

Initial Implementation Date: Sept 5/99

Review Date: July 26/01 / May 3/03 / January 31/06 / December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Bowel Care Protocol

**POLICY:**

This policy is written to provide direction to staff and to ensure adequate, predictable bowel function and prevent gastric complications in the future.

Each resident admitted to the LTC / Convalescent / Respite / RWGH shall have a bowel regime documented according to their individual needs.

**PROCEDURE:**

Upon admission the resident / family will be asked to discuss the regular routine for bowel management. Dependent on the individual response the following guidelines will be maintained. If the routine of the resident is slightly different the Protocol will be adjusted to accommodate this.

Night staff will prepare a Bowel Care Report for the Day shift. The information required for this report will be obtained from the PCC\_Reports\_POC\_look back report\_bowel movement.

The following protocol will be followed as outlined below / dependent on the documentation on the Flow sheets.

**Routine Protocol:**

* Jam Lax to be given at all meals (Breakfast / Lunch / Supper)
* Dietary staff will place Jam lax / Prune Juice at the resident’s place setting in the DR
* or on tray if applicable.
* CCA will ensure the Jam Lax / Prune juice is taken and document if not
* Fluids will be offered at all meals and in between meals

Day 2 (if no bowel movement ) laxative, as prescribed by doctor, given at 0800hrs

Day 3 (if no bowel movement) a suppository / or fleet enema, as prescribed by doctor will be given / if no results then resident will receive a second laxative at 1600hrs followed by sufficient fluids.

Day 4 (if no bowel movement) a suppository / or fleet enema, as prescribed by the doctor will be given. If no results consult physician for further orders.

The results of the above procedure ***MUST*** be reported at shift report and results ***MUST*** be documented on the Bowel Care Sheets located on the flow sheets of all residents. If the results are less than normal documentation ***MUST*** also occur in the progress notes. Additionally the actual administration of the Suppository or Fleet enema ***MUST*** be documented, by the staff member who did the procedure, on the TREATMENT sheets for each resident.

Initial Implementation Date: March 6/07

Review Date: November 25/07 / July 4/08 / December 1/13

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Catheterization

**POLICY**

WBSCH will follow the RQHR nursing procedure for Catherization (urethral)

* Insertion
* Care of indwelling catheter and drainage system
* Removal of an indwelling catheter

**REFERENCE**

* RQHR (2016), Catheterization (Urethral). Code C.9
* Potter & Perry (2014), Canadian Fundamentals of Nursing 5th Edition.
* Frequency of Long-Term Urinary Catheter Replacement in Continuing Care Settings (2015)

Initial Implementation Date: June 1, 2005

Review Date: December 2016

Recommended by: Susan Wood / Director of Care Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved by: Ivy Scobie / Executive Director Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_