

RN Protocol: Constipation/Diarrhea

I. POLICY

- A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients presenting with symptoms consistent with constipation and diarrhea.
- B. Circumstances under which the RN may perform the function:
 - 1. Setting: Outpatient clinic
 - 2. Supervision: No direct supervision required.

II. PROTOCOL

- A. Definition: This protocol covers the assessment and treatment of patients presenting with symptoms consistent with constipation and diarrhea. Constipation is defined as abnormally delayed or infrequent passage of usually dry hardened feces (Mirriam Webster Online Dictionary). Diarrhea is defined as abnormally frequent intestinal evacuations with more or less fluid stools.
- B. Subjective:
 - 1. Chief complaint (document in the patient's own words).
 - 2. Date and time of onset.
 - 3. Assess for pain and note location (right/left/upper/lower quadrant; epigastrium) and quality.
 - 4. Rate severity of pain on a scale of 0-10 (0 = no pain, 10 = worst pain).
 - 5. Does the pain radiate to other parts of the body?
 - 6. What makes the pain better? What makes the pain worse?
 - 7. Accompanying symptoms: (cramping, nausea, vomiting)
 - 8. Recent fever
 - 9. Bowel movements: date of last bowel movement. Description of last bowel movement: (diarrhea, constipation, normal, clay colored, black, yellow, green, tarry, bloody).
 - 10. Recent food or drink.
 - 11. Urinary symptoms (e.g., urinary frequency, dysuria, hematuria).
 - 12. History of chronic diseases (Hepatitis, pelvic inflammatory disease, peptic ulcers, abdominal surgery, irritable bowel syndrome, inflammatory bowel disease, thyroid disease).
 - 13. Allergies.
 - 14. Current medications.
- C. Objective:
 - 1. Vital signs and weight. If vomiting include postural pulse and blood pressure.
 - 2. General appearance. Note skin color and turgor.
 - 3. Auscultate bowel sounds: normal, hyperactive, hypoactive, absent.
 - 4. Palpate abdomen for the following: soft, rigid, distended, guarding, rebound tenderness. Note location of your findings.
 - 5. Fecal Occult Blood Testing (FOBT) if history of black, tarry or bloody stools.

D. Assessment:

- Constipation as evidenced by/related to:
- Diarrhea as evidenced by/related to:

E. Plan:

1. If fever > 101.5 F, hypotension, vomiting, moderate or severe abdominal pain, moderate or severe tenderness on palpation, rebound tenderness, black tarry stools, frank bloody stools, or if bloody emesis is present, refer patient to physician **STAT** for further evaluation.
2. If bowel sounds are absent, refer patient to a physician **STAT** for further evaluation.
3. If stool guaiac positive, without any of the above symptoms refer patient to a physician within 24 hours.
4. If none of the signs or symptoms in (1), (2) or (3) are present and patient complains of **constipation** :
 - a. Instruct patient to increase fluids, eat a high fiber diet, exercise regularly and consider one or more of the following:
 - b. Magnesium Hydroxide 400mg/5ml; give 30 cc with 8-12 ounces of water P.O. TID PRN constipation while symptoms persist if no vomiting; or
 - c. Docusate Sodium 100mg 1 to 3 soft gels PO QD PRN constipation while symptoms persist
5. If none of the signs or symptoms in (1), (2) or (3) are present, and the patient complains of **diarrhea**:
 - a. Loperamide HCL 2 mg: 2 caplet PO after 1st loose stool; then 1 caplet PO after each loose stool while symptoms persist; not to exceed 4 caplets in 24 hrs
 - b. Instruct patient to monitor and record frequency and characteristics of stool.
 - c. Instruct patient to follow-up in clinic in 72 hours if vomiting develops or if symptoms persist.
6. All other symptoms: Refer to a physician on a **STAT, Urgent, or Routine** basis.

F. Patient Education:

1. Assess patient's potential for understanding the health information to be provided.
2. Provide patient education consistent with the assessment of the condition.
3. Document the education provided and the patient's level of understanding on the nursing protocol encounter form.
4. Refer patient to other resources as needed. Document all referrals on the nursing protocol encounter form.
5. Advise patient to utilize the urgent/emergent process to access medical care if vomiting develops.

G. Documentation:

All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

- A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with symptoms consistent with constipation and diarrhea, and achieve a minimum score of 80% on the written posttest examination.
- B. Experience: None.
- C. Certification: None.
- D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstrations. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

- E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurse authorize to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____

REVISION DATE: _____

THE PROTOCOL WAS APPROVED BY:

Chief Nurse Executive/Director of Nursing

DATE: _____

Chief Medical Executive

DATE: _____