**Saratoga Bridges**

**Procedure for BM Monitoring and BM Management with Therap**

**BM MONITORING:**

1. It is the responsibility of all DSPs and nursing staff to report and document bowel movements for each individual, *with the exception of individuals who are deemed independent in their medication administration.* In the day habilitation programs, only individuals who are identified as in need of bowel monitoring will be reported and documented.
2. All bowel movements are to be documented in the Intake and Elimination section of the Health Tracking module of Therap by the end of each shift.
   1. **Please follow the key below when recording to ensure consistent documentation:**
      1. S = small- “golf ball” size or smaller. Note: Small BMs are not counted when determining the need for intervention
      2. M = medium
      3. L = large
      4. XL = extra-large (This quantity will appear as an “X” on the Intake/Elimination grid).
3. At the start and end of each shift, the DSP assigned to care for the individual staff assigned to med administration and/or nursing staff will review the Intake and Elimination grid, as well as T-Logs unless there are any issues or concerns.

***IF THE INDIVIDUAL DOES NOT HAVE A BM DURING YOUR SHIFT, AN ENTRY IN THE INTAKE and ELIMINATION GRID MUST BE ENTERED “0” IN ADDITION TO ANY COMMENTS WITH REGARD TO ACTIONS TAKEN and/or POTENTIAL FOR IMPLEMENTATION OF PRNs / STANDARD PROTOCOL INTERVENTIONS; IF THERE IS NOT AN ENTRY IN THE INTAKE and ELIMINTION GRID FOR THE SHIFT PRIOR TO THAT TO WHICH YOU ARE THE ASSIGNED AMAP STAFF, THE RESIDENTIAL NURSE OR RN ON-CALL MUST BE NOTIFIED (just as you would a blank on the MAR)***

**BM MANAGEMENT:**

1. At the start and end of each shift, staff assigned to medication administration will review the Intake and Elimination grid Once reviewed, staff assigned to med administration must check the Medication Administration Record (MAR) to determine if an intervention is needed based on the last documented BM.
2. *Prior to administering any prescribed PRNs, it is the responsibility of the staff assigned to medication administration to check with all resources and ensure the PRN is still indicated.*
3. When a PRN is indicated and administered, staff must:
   1. Document on the MAR and perform follow up documentation in accordance with medication administration policies and procedures
   2. Add the PRN administration to the individual’s Intake and Elimination Grid under “Bowel Aids”
   3. Document the PRN administration and the results in a T-Log
   4. Document the PRN administration and results in the residence’s communication log
4. **It is ultimately the responsibility of the staff assigned to medication administration to ensure that all BMs and any PRN interventions are entered into the Intake and Elimination grid in Therap’s Health Tracking Module.**
5. If a BM concern is noted, the standard protocol interventions appropriate for the individual should be followed:
   1. allow adequate toilet time
   2. increase fluids (unless a fluid restriction is ordered)
   3. offer/encourage prune juice
   4. encourage ambulation and/or frequent changes in position
   5. offer/encourage a warm bath (when available)
6. When an intervention is indicated and provided staff must:
   1. Add the intervention provided to the individuals Intake and Elimination Grid under “Bowel Aids”
   2. Document the intervention and results in a T-Log
   3. Document the intervention and results in the residence’s communication log

**In the event there are no results from implementing the standard protocol interventions and/or the final step in the prescribed regimen, the RN/Nurse on Call must be notified.**

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2. **It is ultimately the responsibility of the staff assigned to medication administration to implement the standard protocol and ensure that all BMs and any interventions provided are entered into the Intake and Elimination grid in Therap’s Health Tracking module.**

**PROCEDURE FOR REVIEWING AND RECORDING BOWEL DATA IN THE ELIMINATION SECTION OF THERAP’S HEALTH TRACKING MODULE:**

**How to review an individual’s bowel movement data**

1. From the Therap dashboard, left-click the “Health” tab on the left side of the screen. The list of Health Tracking modules will appear. A right-click will bring up a context menu that will not be useful.
2. Left-click “Report” to the right of “Intake/Elimination”. The screen will refresh and “Intake and Elimination Report Parameters Input” will appear in the top region of the screen.
3. In the field “Individual’s Name”, type in the individual’s name. If the individual’s name does not appear, verify that you are using the correct user profile that gives you access to that individual.
4. Set the Begin Date field to five days prior to the current date. Set the End Date to the current date.
5. Check the following boxes in the Type field: # of BMs, BM Type, BM Amount, Bowel Aids, Comments.
6. Left-click the “Search” button. The screen will refresh and show entries meeting the criteria specified in the previous steps.

**How to record a new bowel movement data:**

1. From the Therap dashboard, left-click the “Health” tab on the left side of the screen. A right-click will bring up a context menu that will not be useful.
2. Go to Intake/Elimination,
3. Left-click the word “New” and a new screen will appear.
4. Type in the individual’s name in the field labeled “Individual Name”.
   1. The field will auto-populate with individuals in your caseload. If the person’s name does not appear, verify that you are using the correct user profile that gives you access to the individual.
5. Left-click the box for “Program Name”. Select the program at which the bowel movement occurred.
6. Left-click the icon (little picture) of the calendar and select the date on which the bowel movement occurred.
7. Left-click the “Submit” button. The browser window will refresh, and you will now see “Intake and Elimination Daily Data Input Form” in the top region of the page.
8. First, complete **Section 2**, the Intake and Elimination Grid. To do this, left-click the “Add Intake Elimination Entry” text below the grid. The grid will refresh and text/drop-down fields to be used for recording data will now be available. Proceed to complete the relevant fields, i.e., those specific to the act of elimination.
9. Each bowel movement must be entered separately (even if within same hour time period) using the steps that follow.
10. Begin by recording the time of the elimination event in the field labeled “Time”. Time is divided into 1-hour increments in the drop-down. Select the interval during which the event occurred. If the event, e.g., a BM, took place at midnight, select 12am-1am.
11. The field “Bowel Movement” should be completed with the number of BMs during the specified time period. (this should either be “0” or “1”, refer to Step 9).
12. The field “BM Type” (The items from the Bristol Stool Scale (Type 1- Type 7) should not be used.) should only use the following descriptions: Diarrhea, Hard, Loose, Soft, and Normal *(this step in not applicable to individuals with a colostomy or ileostomy)*
    1. Diarrhea= watery with mucus;
    2. Hard= difficult to pass
    3. Loose= liquid consistency
    4. Soft= not formed
    5. Normal= formed
13. In the field “BM Amount” enter the size of the BM in accordance with the key noted in the BM monitoring section. *(this step in not applicable to individuals with a colostomy or ileostomy)*
14. DO NOT USE the field “Blood in BM”.
15. In the field “Bowel Aids” select from the drop down options what PRN interventions and/or standard bowel protocol was used.(when applicable). A comment must be added and a T-Log submitted if data was entered in this field.
    1. E = Enema (e.g., Fleet, tap water, soap suds),
    2. L = Laxative (e.g., Milk of Magnesia, oral Dulcolax, magnesium citrate),
    3. S = Suppository (e.g., Dulcolax, rectally administered glycerin),
    4. O = Other (element on standard BM protocol- add to comments section).
16. In the field “Reporter” your name will automatically appear.
    1. If you did not witness what is being reported, use the drop down box to select the name of the Therap user who gave you the information.
    2. In the event the information was given from someone other than a Therap user (e.g., parent, other family member, etc.), scroll all the way down to the bottom of the list and left click “Other” then use the text box “If other” to record the reporter’s name.
17. Once you have entered information about the act of elimination (or lack thereof) into the appropriate fields, click the “Add” button.
18. Next, turn your attention to **Section 1**, which contains General Information. If the individual has a colostomy or ileostomy, enter the volume of output). Complete the comments box with information relevant to the elimination event under consideration. Once you have completed the comments, using no more than 3000 characters, left-click the “Add” button. A comments field will appear below the comment entry region, and the comment you added will be listed.
19. When all data has been recorded, left-click the “Submit” button. The screen will refresh and you will see a message stating that the form has been successfully submitted. This action incorporates the information into the permanent record and makes it available for review by others who have access to the individual’s health record.

**\**Reminder: If the individual does not have a BM during your assigned shift, an entry in the Intake and Elimination Grid must be entered “0” in addition to any comments with regard to actions taken and/or potential need for implementation of PRNs / standard protocol interventions; If there is not an entry in the Intake and Elimination Grid from the shift prior to that which you are the assigned AMAP staff, the residential nurse / RN On-Call must be notified (just as you would a blank on the MAR)***

ver. 8-15-16