Vital Sign Graphic Chart
Intake and Output
Bowel / Elimination Record
GEORGIA REGIONAL HOSPITAL/SAVANNAH

Consumer Identification

Date																								
Hospital Stay																								
Weight																								
		A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
		4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
Temperature	106°																								
	105°																								
	104°																								
	103°																								
	102°																								
	101°																								
	100°																								
	99°																								
	98.6°																								
	98°																								
	97°																								
	96°																								
Pulse	150																								
	140																								
	130																								
	120																								
	110																								
	100																								
	90																								
	80																								
	70																								
	60																								
Respiration	50																								
	40																								
	30																								
	20																								
	10																								
Blood Pressure																								

Intake	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM
8-Hour												
24-Hour												
Output	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM	7 AM	3 PM	11 PM
8-Hour												
24-Hour												
Stool												
Bowel Report 7–3:30 PM	# Stools			# Stools			# Stools			# Stools		
N=Normal; **L**=Loose; **U**=Unknown	Appearance			Appearance			Appearance			Appearance		
S=Self; **V**=Visual; **R**=Refused	Reported by			Reported by			Reported by			Reported by		
Nurse Signature												

Notify nurse: 3 days without a BM, 3 loose stools or abnormal stool

Graphic Chart
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		A.M.			P.M.			A.M.			P.M.			A.M.			P.M.			A.M.			P.M.		
		4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12	4	8	12
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Nurse Signature												

PCF-7 (rev. 11/08)

Notify nurse: 3 days without a BM, 3 loose stools or abnormal stool

Georgia Regional Hospital at Savannah
Vital Sign/Headcount Worksheet

Date: **Unit:** 4 Male ☐ Female ☐

Room	Consumer Name	ID#	OBS	Privilege Level	Vital Signs and Staff Initials			BM Monitoring						Headcount			% Consumed			BATH	WEIGHT/INITIAL
					7 - 3	3 - 11	11 - 7	7- 3	Code	3-11	Code	11- 7	Code	7 - 3	3 - 11	11 - 7	B	L	D		

Initials & Signatures: 7 - 3 3 - 11 11 - 7

RN Signatures: 7 - 3 3 - 11 11 - 7

Additional Comments:

Codes: Appearance: N = Normal; L = Loose; U = Unknown
Reported by: S = Self; V = Visual; R = Refused

GEORGIA REGIONAL HOSPITAL/SAVANNAH	DEPARTMENTAL POLICY	Policy #NS-04-054
NURSING DEPARTMENT	BOWEL ELIMINATION	Effective Date: January 2011
		Page 1 of 1

PURPOSE

1. To establish guidelines for monitoring of individuals bowel function.
2. To promote regularity of bowel movements and normal bowel functions.
3. To establish accountability for monitoring bowel functions.
4. To avoid possible constipation or obstruction and associated complications.

PROCEDURES

1. During the completion of admission Nursing Assessment the Registered Nurse is responsible for obtaining the individuals history of bowel function.
2. The Nurse will initiate the Vital Sign/Headcount Worksheet and the Vital Sign Graphic Chart Intake and Output Bowel/Elimination Record.
3. The Charge Nurse will be responsible for ensuring assignments are made to the HST/FST staff regarding individuals for which they are responsible for monitoring bowel function for the shift. (This will be documented on the Staff Assignment Sheet each day and shift.)
4. The HST/FST staff are responsible for asking each individual about his/her bowel function for the assigned shift and document on the and the Vital Sign Graphic Chart Intake and Output Bowel/Elimination Record.
5. The licensed nurse(s) will be responsible to monitor each individual's bowel functions each shift to ensure documentation is completed on the form.
6. The 7-3 shift licensed nurse evaluates each individual's bowel status. If an individual has not had a bowel movement recorded in three (3) days or has positive signs and symptoms of constipation/impaction/bowel obstruction, the nurse will perform an assessment to include auscultation and palpation. The physician will be notified of bowel status and assessment findings. The nurses on 11-7 may notify the physician at the end of their shift if the individual is not in distress and does not have sign and symptoms of bowel obstruction.
7. If the individual has physician orders for bowel elimination problems, the nurse will follow the physician orders. The physician will be notified if there is no response to the treatment within a time frame that is appropriate for the specified treatment or if the individual presents signs of distress.
8. The nurse (s) will communicate bowel elimination issues during the shift report to ensure continuity of care.

PREVENTION CONSIDERATIONS:

1. Encourage fluid intake unless individual has a limited fluid intake order.
2. Encourage increased physical activity.
3. Dietary modifications, consult dietician.
4. Encourage routine schedule for elimination, adequate time, and proper position on toilet. If the individual is unable to utilize toilet, utilize effective positions when in bed. (Lying on the side with knees placed towards chest.)

DOCUMENTATION CONSIDERATION:

1. Documentation in the progress notes of abdominal assessment for individuals without bowel movements in three (3) days will include: Inspection/auscultation/light palpation.
2. Documentation of treatment and responses to treatment will be recorded in the medical record.