

## The Scoop on Poop

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Why would we have to discuss this topic in the middle of a beautiful summer? The “scoop on poop” is one of those articles we have been talking about writing for a very long time, knowing that no matter what season it gets published in, people might not be that excited about reading it.

### Why talk about poop?

If any of you ever had a baby yourself or spent a lot of time with one, you will know that this topic we avoid is one of the most popular topics amongst new parents. Doctors ask questions about colour, texture, smell. Parents track what appears on the diaper like it was gold. If a baby is unhappy, first thing we think about is poop. Does baby need to poop? Is baby constipated? Do we need to switch from rice cereal to barley cereal? From mashed peas to bananas? When young children learn to use the potty, we cheer and give out prizes. But once the skill is mastered, we stop talking about it.

Being regular, particularly in adulthood, is an “irregular” conversation starter. It is one of those topics that seem too “private” or perhaps too “stinky” to discuss in public. But the reality is that how we feel each day is closely tied to our bowels. When they are not working properly, it hurts, and in some extreme situations, it can even lead to death. But because it is not a popular conversation topic, it is also one we tend to veer away from when it comes to the individuals we support. And this is worrisome because it is actually one of the topics that needs to be discussed.

### **Why Yona wanted to write this**

I study health services, and I also worked for many years as a psychologist at the Centre for Addiction and Mental Health in a clinical service for individuals with developmental disabilities and serious mental health concerns. The first time I ever thought about this issue was after reading an article in the Toronto Star about a man who died in the emergency department in his late 20’s (the case is well described in a chapter by Heng and Sullivan, 2003, see reference at the end of this article).



**Hands**

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‘Jack’ was very independent, but also very afraid of medical procedures. The first time he presented to the hospital with abdominal pain and “diarrhea,” the emergency department figured out that he had severe constipation, and his parents, as substitute decision makers, permitted the hospital to treat the constipation, and he was released from hospital. This happened again 18 months later, and he was admitted to hospital, but refused medical investigations. Tragically, he died from medical complications caused by the constipation before medical treatment occurred.

The next time I thought about this issue was as a researcher, completing a study on psychiatric hospitalizations and developmental disabilities. As part of this provincial project, I visited nine regions of our province, each with a psychiatric hospital, and I met with nursing staff, physicians, hospital directors, community agencies and families. I shared with them findings about my project and they told me about the local experience, making recommendations about how we could reduce hospitalizations and improve mental health care. (At this point, you are probably wondering how these talks relate to the current article.) Well, at almost every hospital site, I heard a story about “the patient no one could treat, the one with the worst aggression, hospitalized because of safety concerns.” And with each case, the final diagnosis, once carefully assessed and monitored by a team of psychiatric specialists in developmental disabilities, was constipation.

In the Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario, we learned that adults with developmental disabilities are at greater risk for “preventable hospitalizations” than other adults ([Balogh et al., 2013](#)). Believe it or not, one such preventable hospitalization would be constipation. With proper monitoring, ‘Jack’s’ situation could have been flagged and treated before it became an emergency and he was hospitalized. As staff, we can play a role in helping people to be aware of what is happening or not happening in their bodies, what is “normal” and when they need to worry. If there is a problem, like diarrhea or constipation, there are things that can be done. However, if we don’t ask the question, we won’t know it is a problem. And if we don’t know it is a problem, we won’t do anything about it.

### **Why Angie wanted to write this**

I am a nurse and I work as the Toronto Network of Specialized Care Health Care Facilitator. I have found that the BM chart including a visual of the Bristol Stool Chart is one of the tools I most commonly share with staff. It is part of a series of primary care tools developed for caregivers and it helps to keep track of a person’s bowel health. Far too often, it helps in the “detective work” of identifying possible underlying health issues contributing to complex behaviours.

<http://www.surreyplace.on.ca/primary-care/12-resources-publications/136-tools-for-caregivers>

(See page 9 and 10 for a printed example. You can find other helpful charts for staff on the weblink above too.)

I have been involved in many situations where understanding a person’s bowel issues had a major impact on the person’s quality of life and living situation. For example, ‘Jimmy’ was a middle-aged man with non-verbal communication, living in a developmental services agency residential program. He had increasingly frequent and intense aggressive behaviours and caregivers sought a dual diagnosis team assessment, which identified that he had severe constipation as a major contributing factor.

His community living situation could not meet his changing needs so he went into long-term care where the higher number of residents, fewer staff and sometimes chaotic environment appeared to make him decline even further. Years later and with aging-related changes, health care providers continued to recognize the impact bowel health and constipation had on changing his behaviour. In addition to dietary and other non-medication ways of helping 'Jimmy' avoid constipation, he needed more invasive treatments – suppositories and enemas. After getting to know 'Jimmy,' the long-term care providers continued to advocate that he could live in a community program and 'controlled acts' like suppositories and enemas could be done in developmental service agency programs with the proper training, monitoring, and supports in place. 'Jimmy' visited his new home at a community program and sat happily on his bed in his new room. Hearing this, among other outcomes for people with developmental disabilities that have not gone so well, I really wanted to help caregivers understand the importance of understanding the 'ins and outs' of bowels.

### **Routine, Routine, Routine**

The trick to healthy bowels is establishing routines. The most obvious routine is the toileting routine. But it is equally important to establish a routine around what and when you eat and drink. 'Training' the bowel to evacuate poop routinely might help. This involves toileting at the same time daily especially 10 to 20 minutes after eating a meal like breakfast to make use of the body's gastrocolic reflex that happens in response to food in the stomach and helps to urge the bowel to move stool along the bowel and evacuate it. Proper, comfortable positioning on the toilet, commode or toileting method is also important.

"Preventing constipation is easier than treating it."

[www.uhnpatienteducation.ca/PatientsFamilies/Health\\_Information/Health\\_Topics/Documents/Bowel-routine\\_for\\_Preventing\\_Constipation.pdf](http://www.uhnpatienteducation.ca/PatientsFamilies/Health_Information/Health_Topics/Documents/Bowel-routine_for_Preventing_Constipation.pdf), 2014)

What is considered a 'normal' bowel movement can be different for each person but, generally, constipation is going longer than three days without a bowel movement, and/or difficulty with passing poop that becomes hard dry stool (Type 1 on the Bristol Stool Chart). We are supposed to drink about eight cups of water per day unless a health care provider advises otherwise, to help soften poop. We should combine enough water with a healthy diet which includes fruits, and vegetables and fiber-rich foods. The number of fruits and vegetables vary depending on how old you are, your gender, and size. A 'fruit laxative' can be made with foods like prunes, dates, figs and raisins. You could check with a dietitian on dietary strategies for free by phone or online in Ontario at Eat Right Ontario ([www.eatrightontario.ca](http://www.eatrightontario.ca) 1-877-510-5102). Some foods and drinks can harden poop, and some can soften poop. For example, sugary drinks, refined sugars, fried and starchy foods are harder to digest and can make bowel movements harder. But for many adults with developmental disabilities, these are the foods they eat. Sometimes, finding the balance between supporting people to make their own decisions, and helping people to take the best care of themselves that they are able to is challenging. Just keep in mind during such difficult negotiations that our job is to help people to make informed choices.

So UNDERSTANDING the impact of our food choices is key. Working together on monitoring diet and bowel movements is one concrete way to understanding these associations.

Daily physical activity is of huge importance for a healthy bowel. But for many adults with developmental disabilities, especially when they are not that healthy or mobile, watching TV is much more common than going for a walk or participating in a sport. As staff, we can help to encourage moving the body because it helps lead to moving the bowels! Any movement is good. It might include participating in team sports, walking to the bus stop, moving through the grocery store to buy some healthy foods, or doing a workout with the TV. Yoga is a gentle way to move and stretch the body and there are several positions that can help get things moving. One can even practice chair yoga if moving around is a challenge. (<http://mayallbehappy.org/wheelchair-yoga/>). One popular yoga position is called gas pose, where one leg is brought to the chest while the other is on the ground. It gets that name for a reason...



### **Medications and our bowels**

In the Medications chapter of the Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario ([Cobigo et al., 2013](#)), we reported that nearly one in two adults take two or more medications, and that one in five take five or more medications at the same time. One of the most common side effects of several of the medications prescribed to adults with developmental disabilities is constipation. So maybe we should not be surprised that medications for constipation are amongst the top 10 medication categories that were prescribed to over 50,000 adults with developmental disabilities in that project.

So many different kinds of medications can cause constipation including antidepressants, mood stabilizers like carbamazepine, pain medications like Tylenol 3 or OxyContin, antipsychotics like Risperidone, even iron supplements can be the culprit.

In a previous newsletter about medications (<http://www.thefamilyhelpnetwork.ca/wp-content/uploads/2013/03/sss-v3-issue-5.pdf>), we provided some advice on strategies to address constipation due to medications. But we cannot start to address constipation if we are not monitoring that it is a problem.

### **Colorectal Screening**

In Canada, all adults 50 and above, with and without developmental disabilities, are to get screened regularly for colorectal cancer. It is the third most common cancer diagnosed, and the second most common cause of cancer deaths. Research from the H-CARDD program has shown that adults with developmental disabilities are less likely to get tested for colorectal cancer than other adults (link to <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0118023#sec011>). There are different ways to do this screening (there is the Fecal Occult Blood Test or FOBT, and there is the Colonoscopy for example) and the guidelines on screening can change over time, so it is best to talk about screening with the doctor. Screening is not simple, and staff can play an important role in supporting individuals with disabilities to participate in screening. At the end of the article, we have included some helpful resources developed for staff and for individuals with disabilities that explain how to do screening.

### **Skin Hygiene**

Not wiping properly can lead to skin irritations, bladder infections, and bottom bedsores or other types of infections. Especially for women, cleansing the genital area in one direction, from front to back and discarding the toilet paper or pre-moistened disposable wipes after one-time use and one-way wipe is important because re-wiping the front again with the same tissue or wipe after contaminating it, can cause urinary tract infections. For men and women, if incontinence care is involved, paying attention to cleansing between skin folds is also important. We need to wash our hands after toileting to prevent spreading germs and infections. If assisting someone with personal care, hand-washing before and after the care is essential.

### **Final Tips**

So here are a few tips or things to think about to help everyone be more comfortable. Because a healthy bowel makes a happy person. Think about it. Who here doesn't feel better after a good poop?

1. *Healthy eating, drinking and exercise*
2. *Talk about it: Don't be embarrassed to bring up this topic. It is part of being healthy and we have to be able to discuss it. These discussions can include teaching on what is "normal," prevention of problems, monitoring, and knowing what to do if something is wrong.*
3. *Quiet, steady perseverance; even-tempered care; diligence: to work with patience*

### 3. Practice good poop hygiene

- a. Wiping front to back
- b. A masterful toilet paper fold
- c. Hand-washing when done

### 4. What to do when there is a problem:

*“Just the facts ma’am...” It is important to update the doctor about bowels, stomach aches etc. Bring in a chart monitoring how things are going.*

*Most important is being able to describe a CHANGE.*

Signs of bowel blockage would include: cramping and belly pain around or below the belly button area that comes and goes, vomiting, bloating and a hard belly, constipation, and not passing any gas. You can have a little bit of diarrhea like ‘Jack’ did, even when you are severely constipated.

### Who Can Help?

Most important, these issues should be reviewed “regularly” with the family doctor.

In Ontario, there are many helpful resources available to assist with healthy bowels.

Eat right Ontario ([www.eatrightontario.ca](http://www.eatrightontario.ca) 1-877-510-5102).

Colorectal screening program (<http://www.ontario.ca/page/colorectal-cancer-screening-and-prevention>) is Ontario based.

The Colonversation website is not specifically for people with disabilities, but gives some helpful information, and brief animated video about bowel health and screening in Canada <http://www.colonversation.ca>

CCAC is an Ontario based service (<http://healthcareathome.ca> to find your local CCAC’s contact info): If you call the CCAC, you can get some help from a dietitian. They can come to your home and talk to you and your client. Explain to the CCAC that the person is home bound due to their disability

### Here are some helpful resources that were developed in other parts of the world.

This easy read guide was also developed in the UK. But the guideline about the age when screening starts is different than in Canada.

<http://www.easyhealth.org.uk/sites/default/files/null/bowel%20screening.pdf>

This is a very helpful video that explains in very simple terms how to do the FOBT test at home. It is from the UK so it may be a little bit different than how the test is done in Canada or another country. If you are going to support someone doing the FOBT, it might be helpful to watch a video like this together.

<http://www.easyhealth.org.uk/content/part-2-doing-your-test-kit-home>

This is a resource developed for staff in Scotland, which gives information about bowel health and about colorectal cancer screening. A parallel guide was developed for people with disabilities.

[http://www.bowelcanceruk.org.uk/media/171230/923\\_bcuk\\_scottish\\_carerguide.pdf](http://www.bowelcanceruk.org.uk/media/171230/923_bcuk_scottish_carerguide.pdf)

[http://www.bowelcanceruk.org.uk/media/171227/923\\_bcuk\\_scottish\\_b5.pdf](http://www.bowelcanceruk.org.uk/media/171227/923_bcuk_scottish_b5.pdf)

These and other bowel resources can be found on this page:

<http://www.bowelcanceruk.org.uk/information-resources/bowel-health-and-screening/>

The Centre for Developmental Disabilities and Health in Victoria Australia has also developed lots of health care resources.

<http://www.cddh.monash.org/products-resources.html>

Here is a brochure for people with disabilities about healthy bowels, along with a poster. This is the sort of thing you might want to post in the bathroom.

<http://www.cddh.monash.org/assets/documents/2013-healthy-bowel-brochure.pdf>

<http://www.cddh.monash.org/assets/documents/2013-healthy-bowel-poster.pdf>

The Health meet initiative is part of The ARC, in the United States and they have several helpful resources about health generally, but no specific section on poop yet.

<http://www.thearc.org/healthmeet/self-advocacy-resources>

The atlas chapters mentioned in this newsletter are part of the H-CARDD program and can be accessed from the **H-CARDD website**. The H-CARDD program is always interested in your feedback on how we can best address health care issues and developmental disabilities. Please visit our website ([www.hcardd.ca](http://www.hcardd.ca)) or email us with your comments at [hcardd@camh.ca](mailto:hcardd@camh.ca)

## **References**

Balogh, R. S., Wood, J. R., Lunskey, Y., Ouellette-Kuntz, H., Wilton, A. S., Corbigo, V., Isaacs, B. J., Klein-Geltink, J. E., & Lin, E. (2013). *Chronic Disease Management*. In Lunskey Y, Klein-Geltink JE, Yates EA, eds. *Atlas on the Primary Care of Adults with Developmental Disabilities in Ontario*, pp. 92-116. Toronto, ON: Institute for Clinical Evaluative Sciences and Centre for Addiction and Mental Health.

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**Bowel Movement (B.M.) – Monthly Monitoring Record** (for people who have bowel problems)

Month of \_\_\_\_\_ 20\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ (dd/mm/yyyy)

**PROTOCOL IN PLACE:**  No  Yes  
 If Yes, record use in Protocol box, below

When recording B.M.s, note both **SIZE:** L = Large M = Medium SM = Small e.g., Large soft stool = 

L
S

 or 

L
3

 or 

L
4

  
 and **TYPE:** H = Hard S = Soft D = Diarrhea  
 (for TYPE, numbered 1 to 7, you can also use the Bristol Stool Chart on back of page)

X = Checked with client and no B.M.

DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
1 <sup>st</sup> Stool																																
2 <sup>nd</sup> Stool																																
3 <sup>rd</sup> Stool																																
4 <sup>th</sup> Stool																																
Protocol: what used, when?																																

*Adapted from New Visions Toronto*

**Notes:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SEE OTHER SIDE →**

## Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. <b>Entirely Liquid</b>

Types 1 and 2 indicate constipation (Hard)  
Types 3 and 4 are the easiest to pass (Soft)  
Types 5 to 7 may indicate Diarrhea

### **Reference:**

Lewis SJ. Heaton KW. Stool form scale as a useful guide to intestinal transit time.  
Scandinavian Journal of Gastroenterology 1997; 32(9): 920-4.

## **About the Authors**

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## **Answers to FAQ's about the Newsletter**

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