Name of Institution:

Effective Date:

Last Review Date (if applicable):

Expected Next Review Date:

Protocol Reference (if applicable):

Clinical SITUATION OR TARGET POPULATION

Person 18 years of age or older:

* Receiving palliative care treatment

**OR**

* With a geriatric profile defined as a person with functional decline combined with loss of autonomy or major neurocognitive impairment

indications

A person who has had a decrease in the usual frequency of bowel movements and at least one of the following symptoms for 48 hours or more:

* Stools that are difficult to pass
* Small, hard or large, bulky stools
* Pain or discomfort during defecation
* Feeling of incomplete bowel movement
* Effort to defecate or non-productive urge to defecate
* Absence of bowel movements
* Behavioural change in a person with a neurocognitive disorder

Where services are provided

* Residences
* Hospitalization
* Home care

Professional(s) or Authorized Individual(s)

* *Care settings wishing to write group prescriptions for the initiation or adjustment of pharmacological treatment for fecal elimination in a person receiving palliative or geriatric care using this template* ***must specify the professional(s) or group(s) of professionals in this section*** *who will be able to administer the prescription. The directive in italics (!) must then be removed from the version that is made available.*

**Targeted Professional Activities**

*The group prescription must establish the activity or activities reserved for authorized individuals covered by the prescription. A list of the activities that can be performed under a group prescription is available on the Collège des médecins du Québec website* [*Tableau des professionnels et intervenants pouvant répondre à une ordonnance collective*](https://cms.cmq.org/files/documents/Pratiquer-medecine/activites-partageables/liste-act-reservees-avec-sans-ordonnance.pdf)

*Example: Initiating diagnostic and therapeutic measures according to a prescription*

* Xxxx

Contraindications to the Application of This Prescription

Same contraindications as those specified for application of the national medical protocol, i.e.:

* Presence or suspected presence of intestinal obstruction: vomiting with colic or fecaloid or severe abdominal pain
* Known intestinal perforation
* Acute abdominal pain
* Stoma
* Inflammatory bowel diseases (Crohn's disease, ulcerative colitis, diverticulitis)
* Gastrointestinal bleeding
* Rectal, intestinal, abdominal, urinary, gynecological or pelvic surgery within the last six weeks
* Pregnancy or breast-feeding
* Diarrhea, gastroenteritis or *C. difficile* infection within the last five days
* Taking other medications to treat constipation (e.g., linaclotide, methylnaltrexone, naloxegol, plecanatide, prucalopride)
* Contraindication to the use of all recommended medications
* End-of-life or comfort care (without feeding or hydration)

MEDICAL PROTOCOL

Refer to the national medical protocol [No. 628016](https://www.inesss.qc.ca/fileadmin/doc/INESSS/Ordonnances_collectives/Elimination_fecale/INESSS_PMN_Elimination_fecale_ENG.pdf) of the Institut national d'excellence en santé et en services sociaux available on the website at the time of application of this prescription.

Limitations or Situations Requiring Mandatory Consultation

* Using the group prescription twice in one month
* Allergic reaction to treatment
* Appearance of a contraindication to protocol application
* Failure of oral and rectal treatments
* Persistent abdominal pain despite an unforced bowel movement
* Suspicion of spinal cord compression (unknown): paresthesia, hypoesthesia, new or increased low-back pain, or new vesico-sphincter dysfunction
* After application of the group prescription for people who have no prescribed laxative treatment and who are taking medications that may cause constipation (e.g., opioids, oral iron or calcium).
* After application of the group prescription to people whose initial laxative treatment consists solely of docusate and/or psyllium

**Form of Communication**

*Specify, where applicable, the preferred form of communication for exchanges between the prescribing professional (physician and specialized nurse practitoner) and the professional or authorized individual referred to by the collective prescription for information deemed essential.*

* Xxxx
* Xxxx

Reference Tools and Sources

Complete the liaison form for the community pharmacist; if applicable, consult the template available in the “Medical Protocols and Related Prescriptions” section of the INESSS website.

Identification of the Prescribing Professional

*The collective prescription must include the names of all prescribing professionals, i.e. those who adhere to the prescription, their telephone numbers and their license numbers.*

* Xxxx

**Identification of the Responding Professional**

*This section is intended to help the professional or authorized person applying a collective prescription to identify the responding professional(s), or to provide a mechanism for identifying them.*

*Example: the physician or specialized nurse practitioner on call at the walk-in clinic.*

* Xxxx

Implementation Process

1. **Development of the Current Version**

*Identification of the physician(s), specialized nurse practitioner and collaborating persons involved. It is important to identify all the professionals who will be involved from the outset.*

1. **VALIDATION OF THE CURRENT VERSION**

*Identification of individuals in charge of reserved professional activities.*

1. **INSTITUTIONAL APPROVAL OF THE CURRENT VERSION**

*By signature of the representative of the Conseil des médecins, dentistes et pharmaciens (CMDP) when a physician acts as prescriber and respondent.*

*By signature of the Direction des soins infirmiers (DSI), if the specialized nurse practitioner is the prescriber and respondent.*

***!*** *The collective prescription must be signed by the CMDP representative and the DSI when both parties are involved.*

**Representative of the Conseil des médecins, dentistes et pharmaciens (CMDP)**

Last Name: First Name:

Signature: Date:

**Direction des soins infirmiers (DSI)**

Last Name: First Name:

Signature : Date :

1. **APPROVAL OF THE CURRENT OFF-SITE VERSION**

*By signature of each prescribing professional for whom the collective prescription can be initiated for their patients.*

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| --- | --- | --- | --- |
| Last Name, First Name | License Number | Signature | Telephone Number |
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1. **REVIEW**

Effective Date:

Last Review Date (if any):

Expected Next Review Date:

Signature of Responding Authorized Prescriber (if applicable):

Signature: Date: