**Constipation and Bowel Health Management Plan – A Guide!**

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| **Problem**   * A person has been identified as being at risk of constipation. |
| **Aim**   * Soft, formed stools, passed at least 3 times per week. * Preventing or identifying and managing discomfort and distress associated with constipation. * Identifying measures that prevent or treat constipation. * Self-management wherever possible and support team understanding of measures that will prevent and/or manage the person’s constipation. |

Whenever a person we support has been identified at being at risk of constipation, the Constipation Screening and Referral Tool should be used, and referrals made to the appropriate medical professionals. This will usually be a GP, a Community Learning Disability Nurse or a Continence Advisor. Community Pharmacists are also a good source of advice and information.

This guide is to help you to think about all of the things that should be taken into consideration when compiling an effective Bowel Management Plan for someone you support, who is at risk of constipation. This should always be done in conjunction with the involved Medical Professional. The Bowel Management Plan can consist of a single document or can be made up of several guidance documents within My Support Plan. The Bowel Management Plan or reference to the Bowel Management Plan should also be contained within the person’s Health Action Plan.

Please use this document as a guide and a checklist, but please do remember that it is not exhaustive and circumstances may differ widely from person to person.

| **What should we assess?** | **Why?** | **What should we do?** |
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| Assess the person’s usual pattern of bowel movements, including frequency and consistency of stools.  Use the attached Bristol Stool Chart and/or Stool Chart For People Who Use Pads. | To clearly determine if and when the person is at risk of constipation or is at risk of developing constipation.  *Tell me more…*  Constipation is often wrongly seen as simply causing discomfort, rather than it being a serious health problem, which if goes undiagnosed and untreated can have potentially very serious consequences. | As soon the person is identified as being at risk of constipation, complete **Dimensions Constipation Screening and Referral Tool** and begin bowel monitoring using an appropriate monitoring chart (on paper or using Activate).  Please see the attached example of a monitoring chart. |
| Assess the person’s diet and usual dietary/mealtime habits and routines, including their fluid intake. | Appropriate diet and fluid intake stimulates gastric distention (enlarging) which is necessary for gastrointestinal activity. Irregular mealtimes, types of fluid, amount of fluid and the interruption of usual routines can lead to constipation.  *Tell me more…*  People with dysphagia often have additional difficulties in maintaining hydration. This can also be difficult for people with Profound and Multiple Learning Disabilities, as well as people who are physically unwell.  Fibre adds bulk to the stool and makes passing faeces easier because it passes through the intestine essentially unchanged*.*  Sufficient fluid is needed to keep faeces soft. The digestive system transports fluids; both constipation and diarrhoea can have a negative impact on fluid balance so require monitoring.  Additionally, dehydration increases the risk of UTI’s and cancer of the bladder. | Use the Dimensions document **‘Preparing to visit a GP, Community Nurse or Continence Advisor’** to prepare for and use during appointments with healthcare professionals to discuss the person’s constipation.  Encourage and support the person to have a high fibre diet – aim for at least 5 handful sized portions of fruit and vegetables each day.  As long as there is no medical advice to do otherwise, support and encourage the person to take 6 – 8 cup sized drinks per day. Maintaining the correct fluid level is essential in promoting and achieving good health!  Foe some people, maintaining fluid intake and hydration levels are a challenge. Alternatives to drinking liquids may include foods with high water content e.g. soups, jelly etc.  A person’s level of hydration should be assessed before any laxative medication is commenced. Laxatives can make dehydration worse. |
| Assess the person’s level of activity. | Sedentary lifestyles, such as sitting all day, lack of exercise, prolonged bed rest and inactivity all contribute to constipation.  *Tell me more…*  Movement promotes Peristalsis (the wave-like muscle contractions that move food through the Digestive Tract). It decreases the time food takes to move through the Large Intestine, limiting the amount of water absorbed from the stool into the body – hard, dry stools are difficult to pass!  Aerobic exercise accelerates breathing and heart rate which helps to stimulate the natural contraction of intestinal muscles. Intestinal muscles that contract efficiently help move stools out quickly. Abdominal exercises strengthen muscles that facilitate bowel movements.  We need to acknowledge the impact and influence of a person’s posture and change of positions during each day. People with distorted body shapes and those without active independent movement are at risk. | Plan, promote, support and facilitate as much physical activity as possible on a daily basis.  A straight posture and gravity enable the digestive system to work more effectively. A wheelchair user for example, could benefit from opportunities in supported standing (allowing physical space for organs to work effectively) and gravity to work in favour of the digestive tract’s route etc. |
| Assess and identify any medications the person is taking which might contribute to, or cause constipation. | Constipation risk is likely to increase when people are taking 5 or more medications.  *Tell me more…*  Many drugs can slow down peristalsis. Antipsychotics, anticonvulsants, antidepressants, anticholinergics, hypertension medications, hypnotics, iron and calcium supplements can all cause constipation.  Pain relief, including over the counter meds can cause or contribute towards constipation. Some muscle relaxants, by their nature can also impact and make the digestive processes less effective. Some medications for saliva control can have an influence on general hydration levels. | The person’s GP should review any medication that could be causing constipation.  The GP or medical professionals should always advise on any use of laxatives – as opposed to purchasing ‘over the counter’ remedies.  Pharmacists are also a good source of help and advice! |
| Assess the person’s toilet facilities, including functional ability to use the toilet, taking into account any postural difficulties. | Moving your bowels is a private thing. Some people may find it more difficult if they are anxious or stressed or embarrassed.  *Tell me more…*  Squatting is the best position to open the bowels – see the attached diagrams of the most effective squatting position on the toilet.  Some people may not be able to achieve this position.  *Tell me more…*  Sometimes toilet aids can hamper this ideal posture – for example, those with mobility issues are frequently prescribed raised toilet seating – where the individual may not be as flexed (or muscles as relaxed) because their feet are not flat on the floor. Aids such as splash guards may dig into skin or trigger increased muscle tone or spasms. | Ensure privacy, preserve dignity, encourage independence, and reduce any levels of stress or embarrassment the person may be experiencing.  Consider any environmental aids and adaptions that can be made.  A familiar toilet is key for some people, preferring not to use public or unfamiliar amenities can contribute to problems.  We should be aware of the person’s preferences and usual toilet routine (or think about creating one) – for example, using the toilet after a warm bath or after they’ve eaten breakfast or having a hot drink as soon as they get up. Establishing a good routine and a regular opportunities to use the toilet is key for people who may not be able to indicate they need a bowel movement. It also means that once they’ve opened their bowels they can feel more comfortable and relaxed for the rest of the day.  Consider assessment from an Occupational Therapist or a Physiotherapist. |
| Assess if the person is experiencing distress when using the toilet. | Haemorrhoids, anal fissures or other painful disorders can cause us to ignore the urge to open our bowels, which over time can result in a dilated rectum that no longer responds to the presence of a stool.  *Tell me more…*  Other things that may cause distress at the toilet include the environment, experience or fear of abuse, other previous experiences, lack of independence, lack of understanding and embarrassment. | Tools such as the attached DisDAT can help to identify when a person is in distress.  Warmth from a bath can relax muscles before using the toilet.  Haemorrhoid ointments shrink swollen and painful haemorrhoids. Always consult a Medical Professional before these are used.  Consider discussing with a Medical Professional if pain relief may be required prior to using the toilet. E.g. pain killers/local anaesthetic ointment/lubricant/muscle relaxants. |
| Assess the degree to which the person is responding to or ignoring the urge to open their bowels. | Ignoring the urge to open the bowels eventually leads to chronic constipation because the rectum no longer detects or responds to the presence of the stool. The longer the stool stays in the rectum, the drier and harder it becomes. This makes the stool difficult to pass.  *Tell me more…*  Most people open their bowels first thing in the morning or within 30 minutes of eating a meal or drinking coffee. This is the Gastrocolic Reflex.  Some people may not have the understanding in order to ‘push’ to initiate bowel movement – this can become exacerbated as constipation sets in. | Plan, encourage and support the person to have a regular time each day for opening their bowels.  Using the toilet at the same time each day is an effective way of supporting self-management, irrespective of learning disability. |
| Assess if the person’s independence, or progression towards independence whilst using the toilet, may increase the risk of constipation going unnoticed. | Whilst an aim should always be for the person to be as independent and as ‘self-managing’ as possible, there is a risk that where a person uses the toilet independently, signs of constipation may go unnoticed. The person may feel uncomfortable or embarrassed about mentioning it, or they may not realise themselves.  A person may find it difficult to express their symptoms or feelings if they don’t have the language or the means.  *Tell me more…*  A person’s independence in the toilet can lead to a ‘false sense of security’ in the support team about the person’s bowel health.  Independence is always an aim, but the person must be kept safe at the same time. | A thorough initial assessment of if the person is at risk of constipation will prompt referral to Medical Professionals and the development of a Bowel Management Plan that is appropriate for the persons individual circumstances. This risk can be addressed within the Bowel Management Plan. |
| Consider whether there are any associated medical conditions and factors. | Some medical conditions and other factors are known to decrease peristaltic activity.  *Tell me more…*  Up to 50% of people with learning disability are thought to suffer from regular constipation.  A trained person with the right knowledge will recommend sources of fibre which are consistent with the person’s usual eating habits. Those unaccustomed to a high fibre diet may experience abdominal discomfort and flatulence. A progressive increase in fibre intake is recommended. | Consider and agree the frequency of review if any high risk groups are identified – discuss this with the GP or the Learning Disability Nurse or Continence Advisor.  Consider a referral to a Dietician around dietary sources of fibre that prevent constipation.  The least invasive method of treatment should always be considered first:   * A balanced high fibre diet that comprises adequate fibre, fresh fruits, vegetables and grains. * Aim for at least 5 handful sized portions of fruit and vegetables a day. * Increased hydration promotes softer faeces ­– aim for 6-8 cups of water per day. * A regular time for opening the bowels and giving enough time in the toilet. * Successful ‘training’ of the bowel relies upon regular routine. Facilitating a regular time for bowel movements helps in preventing the bowel from emptying sporadically. * Consider the environment and potential causes of stress. The person should be as relaxed as possible when using the toilet. * Regular exercise and activity. * Abdominal Massage (a non-invasive massage therapy for the treatment of constipation) as part of a wider bowel management plan can improve bowel function. This can reduce the amount of medication required. * With GP approval, a trained Aromatherapist can recommend a bespoke treatment ‘blend’ that stimulates the digestive processes and elimination in particular. Essential oil blends used in conjunction with abdominal massage (both with GP approval & under advice of trained therapist) can be very effective * Be fully aware of the role of medication in both the cause and treatment of constipation.   ‘Stimulant’ laxatives should only be prescribed on a short term basis. ‘Osmotic’ laxatives can be given longer term and may take a day or two to work. |
| Where laxative medication is prescribed, either regularly or on an ‘as required’ basis, assess its safe and effective administration. | Medication should be administered by trained and competent people and should be reviewed by the medical professional on a regular basis.  *Tell me more…*  Laxative medication certainly has a part to play in the treatment of constipation. However it should be considered alongside all other lifestyle factors which may lead to a reduction in the need for medication.  There is a risk that where ‘as required laxative medication is used very infrequently, monitoring of bowel movements may cease or become more informal.  A faecal blockage can stay in a person’s bowel or colon for months or even years whilst the person appears to be using the toilet normally. This can lead to Sepsis which is a serious life threatening condition. | Carers should be supported to be aware of the reasons any medications are prescribed, and also be aware of any possible side-effects.  Is it also worth noting that the actions of laxatives may cause discomfort such as painful abdominal spasms, which can be confused with constipation itself.  Where ‘as required’ laxative medication is prescribed, there should be clear guidance in the person’s support plan about when, how, and how long it should be used for.  **Where only ‘as required’ laxative medication is prescribed, and this is used infrequently, monitoring of the person’s bowel movements should continue to such a time that it is agreed by the person’s G.P., Learning Disability Nurse or Continence Advisor that it may safely cease.** |
| Assess the person’s understanding of what constipation is, what causes constipation, what they can do about it and if they are able to tell someone about it. | Most people see constipation and anything to do with bowels and the toilet as private, and many people feel very uncomfortable talking about it. This can be worse for people with learning disability, who may not understand that what they are experiencing at the toilet is either usual or is something that needs attention. This is more of a concern where a person may not have that understanding but uses the toilet independently. | We can use the ‘easy reads’ that are available at <https://www.easyhealth.org.uk>  and our constipation animation at: <https://www.youtube.com/watch?v=C9jDDOA4pdY>  to help people understand about constipation.  Where the person uses the toilet independently’ and especially if the person has any history of constipation or has been identified as being at risk of constipation, we need to be sure that there are guidelines in My Support Plan that enable us to regularly check with the person that everything is ok at the toilet and to find out if anything has changed or if there are any causes for concern.  We should also ensure that an initial assessment/screening for constipation has taken place using the **Dimensions Constipation Screening and Referral** tool and this has been reviewed at least annually. |
| Assess the understanding of the team who are supporting the person. | Constipation can be seen by many as a simply a discomfort or an inconvenience. Constipation, if left untreated is a potentially life threatening condition.  A knowledgeable, empowered and competent team will be most able to promote and maintain a healthy bowel, whilst at the same time making sure that the person is kept safe.  *Tell me more…*  **Sepsis is a risk as a consequence of prolonged constipation. Sepsis is a serious and life threatening condition – consider if the team need awareness raising around looking out for signs of Sepsis.**  [**https://sepsistrust.org/what-is-sepsis/**](https://sepsistrust.org/what-is-sepsis/) | Consider if the team need more training around the causes and management of constipation generally as well as having sufficient understanding of the person’s individual circumstances.  Consider testing the team’s understanding of the Bowel Management Plan.  Consider contacting the local Community Learning Disability Nurse or Continence Advisor – they can be a great source of education and educational material. |
| Assess the impact of effective communication between all concerned. | Communication is the key to good and thorough assessment and to effective and consistent support.  Sharing of important information, including the Bowel Management Plan, with all people who are involved in supporting the person, is crucial to them maintaining a healthy bowel.  For some people, their emotional wellbeing can be directly affected by their bowel. | Consider the effective use of communication passports or tools such as DisDAT, or use of symbols or other graphics and communication aids which may be helpful.  Consider the effective passing of information between members of the support team. Is the bowel recording chart completed on a daily basis? How is information about length of time between bowel movements or changes in the stool type shared amongst the team?  Who is responsible for monitoring the completion of the bowel recording chart?  We should always be sure to look at any other relevant records, especially in relation to nutrition and hydration e.g. are there changes in what is usual for the person or to their diet, which could signpost immediate and necessary actions. |