NHS
Greater Glasgow and Clyde

CLINICAL GUIDELINE

Bowel Management, Community Nursing

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Summary

A previous guidance document was published by NHS Greater Glasgow in 2014. It was widely distributed to District Nursing (DN) Teams.

Constipation can be a distressing symptom, severity can vary from slight, causing no disruption to daily life, to severe, affecting physical, psychological and social well-being. Overcoming communication barriers associated with open discussion of bowel habits and other sensitive gastro intestinal related symptoms is a skill required and one to be developed in all care settings.

The management of constipation in palliative care is an addition to the original document as is the inclusion of the recommended formulary drugs to help manage and alleviate symptoms of constipation (NHSGG&C Therapeutics Handbook)

Related NHS GG & C Documents

Guidelines on Management of Continence in Adults.

Guidelines for the drug treatment of pain in primary care.

Medication Review – Best Practice Guidelines.

NHSGG&C Therapeutics Handbook. A handbook for prescribing in adults 2014 (Access via Staffnet)

NHSGG&C Formulary (Access via Staffnet)

NHSGG&C Guidelines for bowel management (2014)

GG&C Palliative care guidelines on Staffnet

Relevant National Documents

RCN Caring for people with colorectal problems (2002).

Guideline for management of neurogenic bowel dysfunction after spinal cord injury (2009).

RCN management of lower bowel dysfunction, including DRE and DRF (2012).

NICE; faecal incontinence (2007).

Guidelines for Management of Neurogenic Bowel Dysfunction in Individuals with Central Neurological Conditions (2012).

Caring for Stoma Patients, Best Practice Guidelines. CREST (2006, RCN Accredited till 2009).

Consultation

Dieticians, SPHERE Bowel and Bladder Service, District Nursing Teams, General Practitioners, Palliative Care Teams, CHP Prescribing Advisors.

To be reviewed in 2 years by Professional Standards and Clinical Guidelines Group.

Scope

This guidance does not apply to children or people below the age of 18 years of age.

Clinical Audit

It is recommended that these Guidelines be audited within three years of date of approval.

Introduction

Constipation can be a symptom of many diseases and disorders. The management of constipation is a challenge for all healthcare professionals. The importance of educating and training all members of the healthcare team, including care assistants in residential and nursing homes, in the management of bowel care is important. An evidence based approach using a risk assessment tool, management of constipation flow chart, preventative and treatment guidelines should facilitate good practice across NHSGG&C.

If left untreated constipation may lead to rectal loading/ faecal impaction, or even faecal incontinence as a result of the impacted bowel.

Constipation requires immediate assessment if accompanied by symptoms of undiagnosed rectal bleeding, weight loss, abdominal pain and vomiting as may be indicative of colorectal cancer and it is advisable to seek guidance from your GP as soon as possible.

A definition of constipation

Bowel habits vary from one person to, another. The British National Formulary suggests “the passage of hard stools less frequently than the patient’s own normal pattern”. The definition of constipation differs from patients and perspectives.

A consensual definition has been developed based on quantitative criteria assessing defecation difficulties and stool frequency (Rome II criteria).

According to this definition, constipation is diagnosed when at least two out of the following six criteria are present for at least 12 weeks in the preceding 12 months.

- Straining during at least 25% of bowel movements
- Pellet-like or hard stools for at least 25% of bowel movements
- Sensation of incomplete evacuation for at least 25% of bowel movements
- Sensation of anal blockage for at least 25% of bowel movements
- Using manual manoeuvres (including digital evacuation or pressure on the perineum) to facilitate more than 25% of bowel movements
- Having fewer than three bowel movements per week

Applying this standardised definition and using quantitative criteria should become a necessary first step in the management of patients that would help in guiding treatment and monitoring progress.

However in summary constipation can most easily be defined as a variation in an individual’s normal bowel function. People’s perceptions of constipation vary greatly and normal bowel function may involve defecation three times daily or once every three days, but diagnosis may take place when there is a marked reduction in the amount of stools and/or reduced frequency of defecation.

Types of Constipation

Chronic - Long standing constipation either because of medication or long term condition.

Acute - Constipation has suddenly occurred either because of holiday, antibiotic therapy, surgery, pregnancy, inadequate fluid and/or fibre intake. This can be changed through lifestyle modification.

Impacted - The constipated stool is lodged in the colon (descending, transverse, ascending) requires oral and rectal medication to alleviate the problem.

Idiopathic – Idiopathic constipation is when the bowel is underactive and can be termed functional constipation. The condition tends to start in childhood and persists throughout life and there is no known cause. Specialist advice is recommended.

Further Investigation & Specialist Treatment

Referral for further investigation is essential if patients present with any of the following 'red flag' symptoms.

- Change in bowel habit from own normal pattern for more than 6 weeks.
- Undiagnosed rectal bleeding.
- Abdominal pain.
- Passing mucus or blood per rectum.
- Unintentional anorexia and weight loss.
- A family history of bowel or ovarian cancer

In addition the early detection of colorectal cancer in primary care patients over 45 years needs to be considered.

All healthcare professionals

Are responsible and accountable for their own practice in relation to the assessment and management of patient's with constipation (NMC Code of Conduct (2008), NMC Standards for Medication (2010) and NMC Standards of Proficiency for Nurse and Midwife Prescribers (2006)). In addition, all staff should be aware of the National Occupational Standards relating to continence care and familiarize themselves with these competencies. http://www.skillsforhealth.org.uk

Will initiate simple treatment and health promotion activities to maintain continence and promote self care.

Who is at Risk of Suffering from Constipation?

People at risk of constipation include:

- Those taking more than five prescribed medications.
- Those taking individual medications likely to cause constipation, anticholinergic drugs, opiate analgesics, iron, nifedipine/verapamil, aluminium containing antacids or calcium containing preparations.
- Frail elderly or immobile younger adults.
- Nursing home or care home residents.
- Patients with Parkinson's disease, multiple sclerosis, spinal cord disease or injury, stroke, diabetes mellitus, chronic renal failure, clinical dehydration.
- Patients with hypothyroidism, uraemia, hypocalcaemia or hypercalceamia.
- Patients with learning disabilities or cognitive impairment, e.g. dementia, Alzheimer's.
- Terminally ill or palliative care patients.
- Post-operative patients.
- Pregnant or post-natal women.
- Lack of teeth or poorly fitting dentures, swallowing difficulties.
- In addition patients with Coronary Heart Disease with constipation are at a higher risk of cardio vascular events if straining on the toilet.
- Confused and/or depressed patients may ignore the sensation of stool in the rectum, leading to constipation.

Causes of Constipation

There are a number of factors that can lead to, or cause, constipation:

- A diet that is insufficient in or lacks adequate fibre.
- Insufficient fluid intake.
- Organically derived delay in colonic transit time.
- Evacuation difficulties caused by hard impacted stools or nerve damage.
- Anorectal conditions e.g., haemorrhoids or anal fissure, rectal prolapse, rectocele, anismus (contraction rather than relaxation of the anal sphincter), megacolon or megarectum.
- Bowel disorders such as inflammatory bowel disorder, Irritable Bowel Syndrome, diverticular disease and carcinoma.
- Surgical or diagnostic procedures, post-operative constipation.
- Habit or routine such as ignoring the desire to open bowels.
- Polypharmacy or multiple medications.
- Spinal injury/disorders.
- Urinary problems.

Management of Constipation in Adults

Clinicians and trained Health Care Assistants should use the 'Risk Assessment Tool' (Appendix 1, Page 21) to guide them in the management of patients presenting with constipation. Guidance on the role of health care assistants in lower bowel care can be found in the Management of Lower Bowel Dysfunction, including DRE and DRF (RCN 2012) and delegating to non-regulated staff visit http://nmc-uk.org and http://www.rcn.org.uk.

Management, dietary and lifestyle advice and treatment with laxatives or further referral should then be offered.

Digital Rectal Examination (DRE): Mention of DRE is included for completeness as following referral to the Community Nursing Team this technique may be required to further assist patient management.

DRE is the insertion of a lubricated, gloved finger into the anal canal and then rotated gently in a clockwise motion in order to ascertain the type of stool in the anal canal.

It can initiate stimulation of the bowel and thus elimination may occur naturally. Competence to perform this technique must be demonstrated before undertaking as per RCN Guidelines (2012). Full training and assessment is required prior to undertaking this procedure. The performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff. Such supervision should be documented and counter signed by the supervisory nurse as part of the induction/ competency framework and held within the staff member's personal portfolio.

Management of Adult Constipation for Nurses trained in DRE - Appendix 9, is included for completeness as a reference for nurses competent to use DRE.

Additional Tools

Ideas to increase your fibre intake - Appendix 2, Page 22. Fluid Intake Matrix – Appendix 3, Page 23.

Bowel Habit Diaries – Appendix 4, Page 24 & 25.

Food and Fluid Record Diary – Appendix 5, Page 26.

Management of Constipation in Palliative Care – Appendix 6, Page 27. Bristol Stool Chart3 – Appendix 7, Page 29.

Management of Adult Constipation by Nurses trained in DRE– Appendix 8, Page 30.

Standard advice is to increase fluid, fibre and exercise. It is not always possible to achieve this in frail elderly and immobile patients however where possible consider passive exercises, walking short distances, standing up from chair to relieve pressure areas.

Look at dietary fibre intake using food record diary (Appendix 5) and fluid intake using matrix (Appendix 3), advise accordingly. Use ideas regarding fibre intake (Appendix 2) and monitor outcome using the bowel habit diaries (Appendix 4) together with food record diary. Assess patients nutritional status using the MUST tool. If patient is undernourished consider involving dietician for advice regarding nutritional supplements with added dietary fibre. Ask family/ carer for support e.g. to buy favourite fruit etc.

Elderly patients or those with learning disabilities may require the assistance of a relative or carer to manage their fibre and fluid intake and complete a bowel diary on their behalf. In line with a person centred care approach patients/ clients and carers should be fully involved in a three way dialogue with the health care professional which ensures their wishes and the advocacy role is respected. A bowel habit diary for use by carers can be found at Appendix 4.

Review medication - medications that may cause or aggravate constipation, such as sedatives, analgesics, anticholinergics. Ask pharmacists or GP for assistance with medication review.

Fluid intake- use fluid matrix to determine appropriate fluid intake and encourage small quantities frequently. (See Appendix 3, Page 23).

Look at toileting aids to ensure stability and correct position on toilet - involve occupational therapist, use of raised toilet seats (can the person sit with their feet firmly on the floor, or is a step required), toilet frames to provide stability.

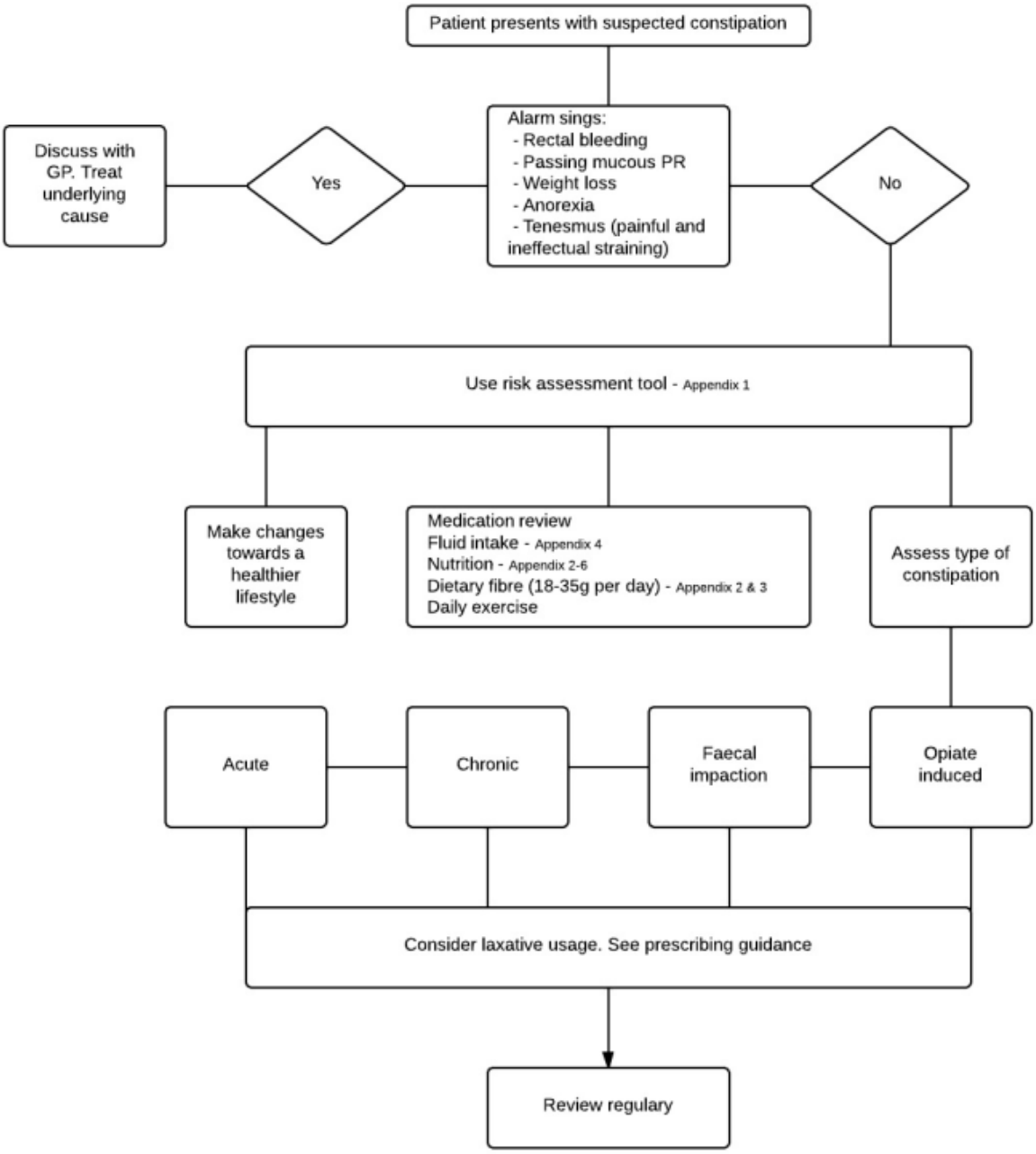
Discuss with patient what their normal triggers are for going to the toilet, such as first cup of coffee, or after breakfast, and help them to maintain or develop a routine where possible.

Liaise with physiotherapist, occupational therapist, dietician, continence adviser, GP, pharmacist, and care assistant.

However use of laxatives may be a necessary part of patient's treatment management plans.

Ongoing monitoring should be a feature of good clinical care. Once effective management is established patients should be able, and be guided, to take responsibility for self management by making adjustments to lifestyle or laxative use as appropriate.

Treatment of Constipation in Adults Flowchart General Management



Formulary Drug Choices (To be considered in relation to current NHSGG&C Formulary Guidance)

Bulk Forming Laxatives

These laxatives are effective in simple chronic constipation arising from a low fibre, low fluid diet. They increase the faecal bulk by directly increasing the volume of faecal material, which stimulates peristalsis.

Formulary Choice – Isphagula husk TM (Sachets) (Preferred List).

Contraindications

- Intestinal obstruction.
- Swallowing difficulties
- Atonic colon.
- Faecal impaction.

Side effects

- Flatulence and abdominal distension.

Prescribing points See also chart on page 17.

- May take several days to have an effect.
- Must be mixed with water and taken as a drink as soon as prepared.

Additional fluid should be drunk throughout the day. (May not be suitable for frail elderly people).

- Not to be taken before going to bed in order to reduce the risk of obstruction.
- May reduce appetite.

Stimulant Laxatives

Stimulant laxatives increase intestinal motility and work quickly.

Formulary Choices

- Senna, (Preferred list)
- Docusate Sodium (Preferred list)
- Bisacodyl (Total formulary)
- Glycerol Suppositories (Total formulary)

Co-danthramer TM (Preferred list) and co-danthrusate TM (Total formulary) are limited to the management of analgesic induced constipation in terminally ill patients and should only be prescribed in consultation with a Medical Practitioner.

Contraindications

- Abdominal obstruction.
- Acute surgical abdominal conditions.
- Acute inflammatory bowel disease.
- Severe dehydration.

Side effects

- Abdominal cramps.
- Danthron preparations may colour urine red.
- Excessive use can cause diarrhoea and related effects such as hypokalaemia.
- Bisacodyl suppositories may cause some local irritation to the rectum.

Prescribing points See also chart on pages 17-19.

- Chronic use should be avoided as can cause fluid and electrolyte imbalance and colonic atony.
- Docusate sodium probably acts both as a stimulant and as a softening agent.

The laxative effect of senna and bisacodyl orally is seen within 8-12 hours so they should be taken at night to produce a morning bowel movement.

Bisocodyl suppositories act in 30-60 minutes.

Docusate acts in 1 to 2 days.

Osmotic Laxatives and Enemas

Macrogols and Lactulose retain fluid in the large intestine by osmosis, causing intestinal distension and eventual peristalsis.

Formulary Choices

- Macrogol 3350 (Laxido Orange TM) (Total Formulary).
- Lactulose TM (when other laxatives can not be tolerated) (Preferred List).
- Sodium Citrate Rectal (Microlax micro enema TM) (Total Formulary).
- Phosphate Enema (Total Formulary).
- Magnesium Sulphate (Specialist only not on NPF). Information only. Specialist bowel preparations will have specific patient instructions.

Contraindications

- Intestinal obstruction / perforation.
- Lactulose is additionally contraindicated in galactosaemia.

- Macrogols are additionally contraindicated in severe inflammatory conditions of the GI tract and paralytic ileus.

Side effects

- Cramps, nausea, flatulence and general abdominal discomfort.
- Phosphate enemas may cause local irritation and electrolyte imbalance.

Prescribing points See also chart on pages 17-19.

Can lead to dehydration if inadequate fluid intake. (Dehydration can manifest as confusion and renal impairment especially in the elderly).

Lactulose is best administered with either water or fruit juice or meals to reduce the risk of nausea. Requires regular dosing and takes at least 2 days to have any effect. Not suitable for rapid relief.

Laxido includes electrolytes to help protect against loss of potassium or sodium. Once reconstituted the solution should be kept in a refrigerator and discarded if unused after 6 hours.

Do not administer phosphate enemas for disimpaction unless under supervision by General Practitioner/ nurse, and only if all oral medications and sodium citrate enemas have failed (NICE 2010). Administration should follow only after robust assessment (BNF). Additional guidance is contained in Appendix 9.

Faecal Softeners

These products assist mucous in the lubrication of faeces to promote easier passage as well as softening faeces. Docusate sodium also possesses some stimulant activity. Softeners should be used to avoid straining during defecation (e.g. after myocardial infarction, surgery or in hernia or anorectal problems).

Formulary Choices

- Arachis oil enema TM (Total Formulary)

Contraindications

- Arachis oil enema avoid if nut allergy.

Bowel Cleansing Solutions

Formulary Choice

- Nil on NPF.
- Sodium Picosulfate (On specialist recommendation only). Specific guidance will be provided for individual patients.

Management of Constipation in Pregnancy

If dietary and lifestyle changes fail to control constipation in pregnancy, moderate doses of poorly absorbed laxatives may be used. A bulk forming laxative should be tried first. An osmotic laxative can also be used. Senna may be suitable if a stimulant effect is necessary. See British National Formulary or Summary of Product Characteristics for advice re individual preparations.

Table Illustrating Formulary Drug Choices (Extract from NHSGG&C Therapeutics Handbook)
http://handbook.ggcmedicines.org.uk/guidelines/gastrointestinal-system/management-of-constipation/

Indication	Laxative	Dose	Time to take effect	Additional information
Acute constipation	1st line oral therapy Senna tablets/liquid	2 – 4 tablets at night 10 – 20ml at night	8 – 12 hours	Chronic use may lead to colonic atony, tolerance fluid and electrolyte imbalance. Doses may be further increased if required.
	Glycerol suppositories	4 g PR daily	5-15 minutes	Moisten suppositories with water for ease of insertion.
	Sodium Citrate Micro Enema	Insert 1 (5ml single dose) as required	5-15 minutes	
Chronic Constipation Requires long term management +/- Senna (2 tablets at night)	Ispaghula Husk (Fybogel)	One sachet morning and afternoon	1 – 2 days	Ensure adequate fluid intake. If ineffective after several days add senna 2- 4 tablets at night (short tern only). Avoid in intestinal obstruction, decreased muscle tone and following bowel surgery. Do not give at night.
	Macrogols Oral Powder (Laxido Orange)	1-3 sachets daily	1-3 days	Dose can often be reduced to 1 –2 sachets daily for maintenance. Ensure adequate fluid intake.
	Lactulose	15ml twice daily regularly	2 – 3 days	Use where other laxatives can not be tolerated. Unsuitable if rapid relief is required. For maintenance dose can be reduced to meet individual needs

Indication	Laxative	Dose	Time to take effect	Additional information
Impaction	Bisocodyl suppository AND Glycerol suppository	1 of each	15-30 minutes	
	Sodium Citrate Microenema	Insert 1 (5ml single dose) as required	15- 30 minutes	
	Macrogol Oral Powder (Laxido Orange TM)	8 sachets daily dissolved in 1 litre of water and taken within 6 hours for up to 3 days	1 – 3 days	Reconstituted solution should be kept in refrigerator and discarded after 6 hours
If no result followed by:	Phosphate enema	One in the morning	15- 30 minutes	Do not use more than twice a day. See Appendix 9.
	Arachis oil retention enema	One	15-30 mins	Avoid if nut allergy
If no result followed by 6-8 hours later	Sodium Citrate Microenema **OR**	1		
	Phospate Enema **OR**	1		
	Macrogol Oral Powder (Laxido Orange TM)	8 Sachets daily for up to 3 days		May not be possible to use this dose in the frail elderly For use in resistant cases of impaction. Ensure adequate fluid intake.

Indication	Laxative	Dose	Time to take effect	Additional information
Chronic analgesic/opioid induced constipation e.g. codeine, dihydrocodeine, tramadol, morphine	1st line oral therapy Senna tablets Or Senna liquid	2 – 4 tablets at night 10-20ml at night	8 – 12 hours	Chronic use may lead to colonic atony, tolerance, fluid and electrolyte imbalance. Consider intermittent usage or lowest effective dose.
	Lactulose	15 mls twice daily regularly	2 – 3 days	For maintenance dose reduce to meet individual needs
	Or Sodium Ducosate	100-500 mg daily		
	Or Co-danthramer capsules Co-danthramer liquid	 1-2 at night 5-10 ml at night	6-12 hours	**For terminally ill patients only.** Titrate dose upwards as necessary. May colour urine red. Only when response to other laxatives is ineffective.

Note: Patients unable to swallow, but with a nasogastric or RIG/PEG tube in situ can have certain laxative preparations administered via the tube. Contact community pharmacists or enteral feeding teams for details.

Education & Training

Training will be available for community nursing teams co-coordinated by the Practice Development Nurses in line with the competency framework for district nursing.

The Guidelines will be disseminated widely across NHSGG&C and locally training arranged as appropriate.

References

1. Additional information Co-danthramer. This can cause discoloration of urine and bowel and liver tumors. http://clinicalevidence.bmj.com/ceweb/conditions/spc/2407/2407_I5.jsp

2. Bristol Stool Chart, Dr K.W. Heaton and S.J. Lewis, University of Bristol

3. British National Formulary www.bnf.org

4. NHSGG&C Formulary

5. NHSGG&C Palliative care guidelines. http://www.palliativecareguidelines.scot.nhs.uk

6. Nursing and Midwifery Council website. http://www.nmc-uk.org

7. Palliative care guidelines- constipation. http://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/Constipation.aspx

8. Royal College of Nursing – Management of lower bowel dysfunction, including DRE and DRF. 2012. http://www.rcn.org.uk/__data/assets/pdf_file/0007/157363/003226.pdf

9. Skills for Health Continence care suite, available from http://www.skillsforhealth.org.uk via the competence search tool.

10. Thompson WG, Longstreth GF, Drossman DA, et al. Functional bowel disorders and functional abdominal pain. Gut 1999 Sep; 45 Suppl.2:1143-7

Useful Contacts

SPHERE Bowel and Bladder Service: Telephone 0141 531 8612

Fax 0141 531 8523

Appendix 1

RISK ASSESSMENT TOOL

Medical condition	tick
Cancer	
Clinical depression	
Diabetes	
Haemorrhoids, anal fissure rectal problems	
History of constipation	
Impaired cognition	
Multiple Sclerosis	
Parkinson's Disease	
Rheumatoid arthritis	
Post operative	
Spinal cord injury	
Stroke	
Other	
Current medication	
Aluminium antacids	
Anticholinergics	
Anti Parkinson drugs	
antipsychotic	
Calcium channel blockers	
Calcium supplements	
Diuretics	
Iron supplements	
NSAIDS	
Opioids	
Tricyclic antidepressants	
Polypharmacy(more than 5 drugs)	
Mobility	
Restricted to bed	
Restricted to wheel chair/chair	
Walks with assistance/aids	
Walks short distance but less than 0.5km	
Toilet facilities	
Needs bed pan/Commode	
Has a commode by bed	
Supervised use of the toilet/commode	
Raised toilet seat/foot stools	
Nutritional intake	
Fibre intake less than 6g per day	
Difficulty swallowing/chewing	
Needs assistance to eat	
Fluid intake	
Minimum per day	
How long have you had constipation	

PATIENT'S NAME	
DATE OF BIRTH	
CHI NUMBER	

Questions

If more than 4 ticks full assessment is needed

ACTION CHECKLIST	
Complete full bowel assessment using	
Monitor and record bowel movements daily using the Bristol Stool Chart and bowel record chart	
Stool type 1 or 2 prescribe appropriate laxative	
Advise on toileting position	
Review medication including over the counter	
Advise on ways to improve mobility	
Encourage patients to achieve at least minimum fluid intake	
Improve nutrition according to nutritional intake	

Questions

The following questions can help to identify and assess the severity of constipation:

1. How long have you had the problem?
2. Do you feel the need to go and then can't
3. Is Defecation painful?
4. Can you pass stools easily or do you have to strain?
5. How often do you go and how would you describe the stools?
6. How is this different from your usual pattern?
7. Do you need to manually assist? E.g., perineal support, vaginal support (thumb in vagina) or manual evacuation.

Signature…… Date……

Base……

Appendix 2

Here are some ideas to help you increase your daily fibre intake

FIBRE

	FIBRE
A bowl of Shreddies	6.0g
A wholemeal cob	4.8g
An apple	1.7g
A portion of brown rice	2.5g
2 tomatoes	1.7g
A wholemeal fruit scone	2.6g
	TOTAL: 19.3g
A portion of baked beans	13.2g
2 slices of wholemeal bread	5.2g
	TOTAL: 18.4g
A jacket potato	3.2g
4 figs	10g
A bowl of fruit and fibre	5.1g
	TOTAL: 18.3g
8 prunes	4.8g
A portion of whole-wheat pasta	6.0g
Mixed salad	2.7g
A bowl of porridge	4g
A banana	2.4g
A pear	2.3g
	TOTAL: 19.9g

Appendix 3

FLUID INTAKE MATRIX

TO DETERMINE SUGGESTED

VOLUME **INTAKE PER 24** HOURS

This matrix form is used following an assessment for continence; it is a guide to assist patients reaches their optimum fluid intake whilst following a treatment plan.

It is suggested that patients fall within a margin of error of +/-10% - the guideline applies to body frame and gross obesity should not be take as a guide for increasing fluid. Activity levels should be taken into account.

PATIENT'S WEIGHT Stones	KGs	ML	FLUID OZ'S	PINTS	MUGS
6	38	1,190	42	2.1	4
7	45	1,275	49	2.5	5
8	51	1,446	56	2.75	5-6
9	57	1,786	63	3.1	6
10	64	1,981	70	3.5	7
11	70	2,179	77	3.75	7-8
12	76	2,377	84	4..2	8
13	83	2,575	91	4.5	9
14	89	2,773	98	4.9	10
15	95	2,971	105	5.25	10-11
16	102	3,136	112	5.5	11

REFERENCE:

Abrams & Klevmar "Frequency Volume Charts – an indispensable part of lower Urinary tract assessment" 1996 Scandinavian Journal of Neurology 179; 47-53

Appendix 4

Name

CHI Number

NHS Greater Glasgow and Clyde

MANAGING CONSTIPATION - BOWEL HABIT DIARY

Date/Time of Bowel Movement	Time/Type of laxative taken	Stool type (see descriptions)	Did you reach the toilet on time?	Did you use a lot of toilet paper?	Did you mark your underwear or pad?	Did you strain?	Any other comments e.g. blood/mucus
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	
			Yes/No	Yes/No	Yes/No	Yes/No	

Client/Patient's Carer/Advocate to complete:- Client/Patient's Name:-

Client/Patient's CHI No.

Bowel Habit Diary (Carer/Advocate to complete)

NHS Greater Glasgow and Clyde

Date/ Time of Bowel movement	Time/ Type of laxative taken	Stool type (see descriptions)	Reached the toilet on time?	Used a lot of toilet paper?	Marked underwear or pad?	Any straining?	Any other comments e.g. blood/mucus	Carers/Advocates Initials
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		
			Yes/No	Yes/No	Yes/No	Yes/No		

SIGNATURE WHEN COMPLETED

To be used as part of agreed treatment plan. Consent re monitoring of bodily functions to be discussed with client/patient/carer and appropriate managers

Appendix 5

Name

CHI Number

Date:

FOOD & FLUID RECORD DIARY

MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							
SUNDAY							

Appendix 6

Management of Constipation in Palliative Care

Opioid Induced Constipation

This management guidance is taken from the UK Palliative Care Formulary (PCF) Guidelines: Opioid – Induced constipation. The formulary choices outlined here are compatible with those in the main document.

Although some strong opioids are less constipating than morphine (e.g. buprenorphine, fentanyl, methadone, tramadol), most patients receiving any opioid regularly will need a laxative concurrently. Thus, as a general rule, all patients prescribed morphine (or other opioid) should also be prescribed a laxative. The aim is to achieve a regular bowel action without straining, generally every 1–3 days.

Ask about the patient's past (premorbid) and present bowel habit and use of laxatives;

record the date of last bowel action.

Palpate for faecal masses in the line of the colon; examine the rectum digitally if the bowels have not been open for more than 3 days or if the patient reports rectal discomfort or has diarrhoea suggestive of faecal impaction with overflow.

For inpatients, keep a daily record of bowel actions.

Encourage fluids generally, and fruit juice and fruit specifically.

It is sometimes appropriate to optimize a patient's existing laxative regimen, rather than change automatically to co-danthramer.

When prescribing co-danthramer strong or co-danthrusate:

	Co-danthramer strong capsules	Co-danthramer strong suspension	Co-danthrusate capsules	Co-danthrusate suspension
Dantron content	37.5mg/capsule	75mg/5ml	50mg/capsule	50mg/5ml
Start with:				
prophylactic	1 at night	2.5ml at night	1 at night	5ml at night
if constipated	2 at night	5ml at night	2 at night	10ml at night
If necessary, adjust every 2–3 days up to:				
	3 capsules taken three times a day.	10ml twice daily or 20ml at night	3 capsules twice daily	15mls twice daily
Total daily dose	337.5mg	300mg	300mg	300mg

During dose titration and subsequently, if more than 3 days since last bowel action, give suppositories, e.g. bisacodyl 10mg and glycerol 4g, or a micro-enema. If these are ineffective, administer a phosphate enema and possibly repeat the next day.

If co-danthramer/co-danthrusate causes intestinal colic, divide the total daily dose into smaller more frequent doses, e.g. change from co-danthramer strong 2 capsules twice a day to 1 capsule four times a day. Alternatively, change to an osmotic laxative, e.g. macrogol 3350 (Laxido) 1–2 sachets in the morning.

If the maximum dose of co-danthramer/co-danthrusate is ineffective, halve the dose and add an osmotic laxative, e.g. macrogol 3350 (Laxido) 1 sachet in the morning, and titrate as necessary.

An osmotic laxative, e.g. a macrogol may be preferable in patients with a history of colic with colonic stimulants, e.g. dantron, senna, bisacodyl.

Other Laxatives used in Palliative Care

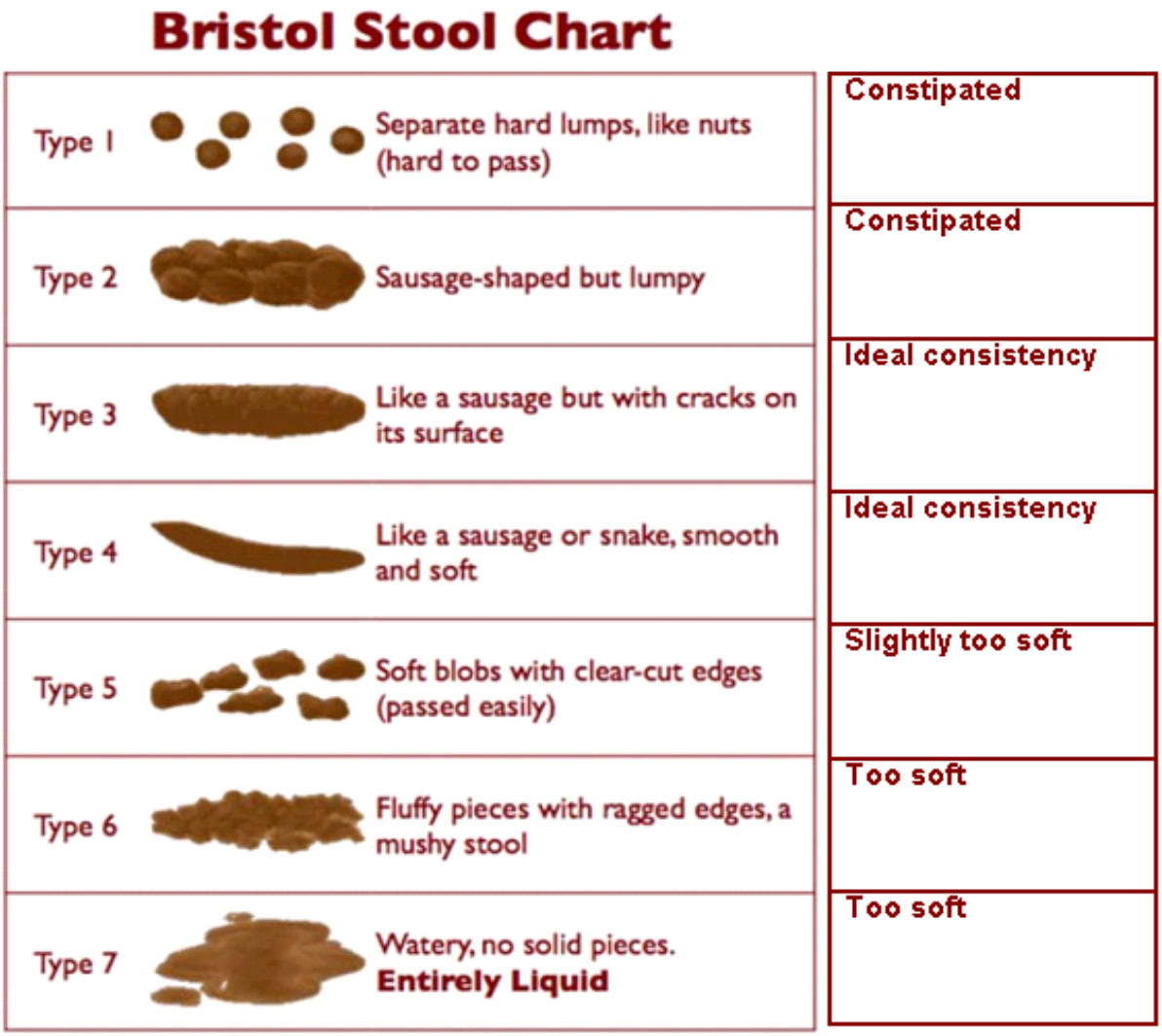
Osmotic laxatives commonly used: Laxido TM and Lactulose.

Stimulant laxatives: Senna, Sodium Picosulfate and Bisacodyl

Please refer to NHSGG& C Palliative Care Guidelines for more information.
http://www.palliativecareguidelines.scot.nhs.uk

Appendix 7

What is Normal Bowel Function?

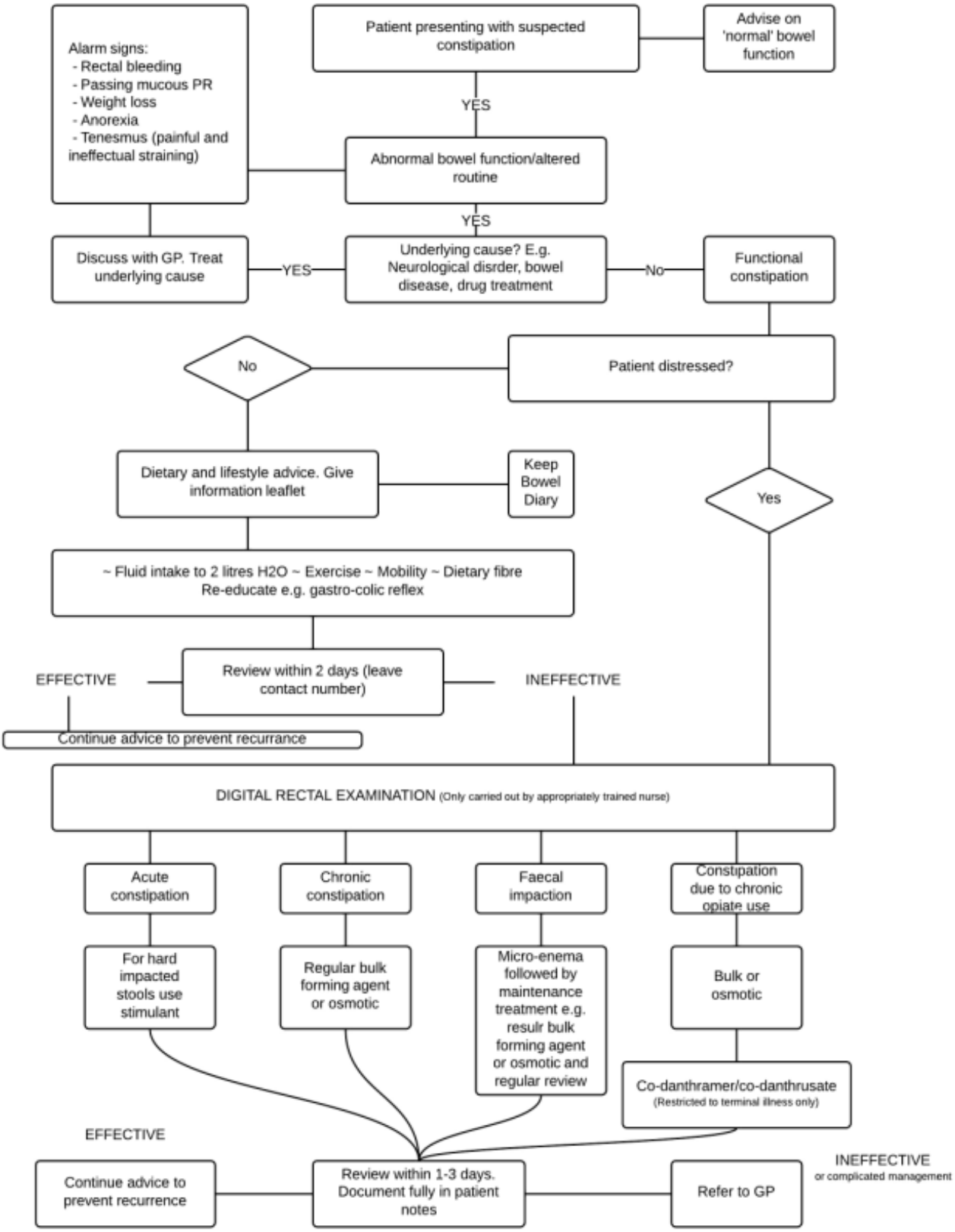


Heaton and Lewis, University of Bristol

People's perceptions of constipation vary greatly and normal bowel function may involve defecation three times daily or once every three days, but diagnosis may take place when there is a marked reduction in the amount of stools and/or reduced frequency of defecation

Appendix 8

Management of Adult Constipation by Nurses trained in Digital Rectal Examination



Appendix 9

Administration of Enemas/ Suppositories.

Best practice information on use of oral aperients provided within NHS GG&C Bowel Care Guidelines should be followed in the first instance. For some patients the administration of an enema/ suppositories may also be required.

Prior to a referral to the District Nursing service for administration of enemas/ suppositories, the General Practitioner (GP) should carry out a clinical examination (NHSGG&C Therapeutics Handbook 2014) and provide the patient with an individual patient prescription and a completed direction to administer form. Nurses require a completed direction to administer form to comply with NMC Standards for Medicines Management and Delegation.

Prior to administration of an enema/ suppositories a robust nursing assessment is required. The outcome of the assessment and the use of the bowel care guidelines should lead the nurse to the most appropriate bowel evacuation/ laxative product for that patient at that particular time. Following assessment the nurse should raise any concerns about the enema/ suppository administration with the referring GP.

British National Formulary cautions use of phosphate enemas in elderly and debilitated. This group may be predisposed to electrolyte disturbances, renal impairment, congestive cardiac failure, ascites, uncontrolled hypertension, and the maintenance of adequate hydration.

Contra-indications are given as gastro-intestinal conditions (including gastro-intestinal obstruction, inflammatory bowel disease and conditions associated with increased colonic absorption). Phosphate enema administration for long term bowel management is not recommended. There is no ban on prescribing/administering phosphate enemas in community.

Good feed back and communication with the patient's GP or Out of Hours GP is paramount to good out comes for distressed and constipated patients.

N.B. Not all community nurses are prescribers. Nurses who are able to prescribe can only currently prescribe for patients on their aligned caseload (Standards of Proficiency for Nurses and Midwives Prescribers, NMC).

Appendix 10

The SPHERE Continence Care Team

- The team is responsible for delivering a high quality and cost-effective service within the resources available. The team aim to ensure that teams across NHSGGC have access to current evidence regarding promotion of continence and management of bladder and bowel dysfunction. To achieve this the team will:

- Endeavour to provide training in a flexible and appropriate way to meet the learning needs of staff.

- Provide specialist advice and support, to enable health care staff to apply first level continence assessments to patients in all care locations.

- Support the development of local policies which incorporate national evidence based clinical practice guidelines and pathways of care to support Health Board-wide implementation and evaluation

- Facilitate the monitoring of quality through clinical audit, taking into account comments and complaints

- Work in partnership with other organisations e.g. other health boards, and statutory and voluntary organizations.

- Provide competency based education and training programmes to all levels of staff and the multi-disciplinary teams within NHSGCC. These training needs will be identified by appropriate training need analysis carried out by local teams within Health and Social Care Partnerships (HSCP).