Care Homes Good Practice Guidance

Maintaining good bowel health and preventing constipation

Contents

Aim

This guidance has been produced to provide care home staff and prescribers with information on how to practically prevent constipation in a care home setting.

Background

Management of constipation is challenging in older people where multiple conditions and multiple medications are very common[1]. Constipation can be missed in older people, residents with dementia or a learning disability. Signs of behaviour changes such as confusion, might indicate they are in pain or discomfort[2].

Constipation is defined as:

Passing stools less than 3 times a week or less then often than usual for the resident. The stools are unusually large or small and is dry, hard or lumpy. The resident is having to straining or in pain when passing stools of feel they haven't fully emptied their bowels[2]

In care homes we often use a medicine to treat constipation, which can increase the resident's pill burden and may not be the most effective way to treat their constipation. There are a lot of practical approaches residents, carers and healthcare professionals can take to reduce constipation. This good practice guidance covers the approaches that can be taken to reduce the risks of constipation using both non-pharmacological and medicines.

Locally it has been identified that one of the most common reasons for residents' admissions to frailty wards via A&E from care homes are constipation and dehydration.

If constipation is not managed correctly stools can become stuck, in the colon, blocking waste from leaving the body. This is referred to impaction which can require more aggressive and invasive treatments which can lead to a hospital stays.

Care Home Environment

Time and feeling safe

It is important when a resident moves into the care home that the staff are aware of the resident's normal bowel movement and usual times. Everyone has a different usual frequency of bowel movements per day/week. This needs to be recorded in their care plan with the aim of supporting the resident to use the toilet around these times.

The resident shouldn't feel rushed, anxious, or uncomfortable. If possible, allow space and privacy. If a resident requests to go to the toilet carers should support them as quickly as possible, because if residents are made to wait then the "urge to go" may pass, causing constipation.

Diet

It is very important to have a high fibre diet which can be from many sources such as fruit, vegetables and whole grains (e.g. cereals). It is also important that enough fluid is taken along with this fibre (see under hydration). However, it is understandable that for some of our residents it is difficult to maintain this. Ensure you understand your resident's routine and preferences to support them to eat and drink. The care home diet may be very different from what the resident was used to. Prior to (or at) admission there should be a discussion of the resident's like and dislikes. Further information on supporting residents (including residents with dementia) with food and drink can be found in the following places:

1. Hertfordshire and West Essex ICB malnutrition pathway
2. Dementia UK eating and drinking
3. Care home digest nutritional food-based standards

Hydration

Everyone unless advised by a medical professional should aim to drink 1600 ml (3 pints) for females and 2000ml (3 ½ pints) for males; more if it is hot weather[5].

Keeping residents hydrated is key to preventing constipation. Offer drinks throughout the day which may interest the residents. See below for some ideas:

Hot drinks	Teas (offer a range of teas), coffees (+/- syrups), hot chocolates; (+/- toppings), Horlicks®. Taste is also affected by the milk type and volume added, so ensure you offer what is preferred by the resident. Use latte cups/-different types of teacups to make the drinks interesting. The type of cup can affect the volume taken, so if the resident has their own preferred mug (especially if this is a high volume one) this may help.
Ice cold drinks	Keep them accessible in fridges (ideally glass fronted) where residents are spending time and offer them frequently. Can include fizzy drinks, -sparkling water with/without squash.
Fun drinks	Mocktails Milkshakes Iced lattes

	Use garnishes to make drinks more inviting
Activities	Include drinks in daily activities Set up tables as tea parties Make drinks (e.g. non-alcoholic cocktail) a social event to encourage more fluid
Toileting	Residents with incontinence issues may restrict their fluid intake because they are worried about reaching the toilet in time. Discuss these concerns with the resident and make a care plan on how you will help them manage these concerns.
Water tablets	Residents taking tablets to reduce fluid overload (e.g. furosemide) may need to have their toilet trips planned around their water tablets. Making sure these are practical for staff can affect when the water tablets should be taken (such as giving them at the end of a medicines round not the start).
Cups and Glasses	Often a generic cup or glass may not be inviting to the resident to drink from. Try to work out if there is something more specific the resident likes. For example for a football fan, a mug with their favourite team on it maybe more inviting.

Increasing hydration is also beneficial for reducing falls, confusion, risks of urinary-tract infections and delirium.

Mobility

Reduced mobility increases the risk of constipation. Encourage mobile residents to mobilise/exercise and support them to do so. Suitable mobility equipment should be available. Use available space such as gardens and use activities that increase movement.

Laxative use

If lifestyle changes do not improve constipation in the first instance then a suitable laxative should be used. If the resident has an as needed (PRN) laxative give this, or homely medications may be given - see individual care plan.

If none of these are accessible, then advice must be sought from prescribers. Quick access to laxatives can prevent impaction, but also it is important to remember regular laxative use can also cause a lazy bowel resulting in the resident becoming reliant on its use.

Some residents may refuse laxatives because of the fear of loose stools or not getting to the toilet on time. It is important to reassure the resident and provide quick and easy access to the toilet when they request it during this time. If incontinence pads are used ensure these are changed quickly if soiled to reduce any stigma around accidents.

Communication

From Healthcare settings:

- If a resident's medication has changed and they have come from a healthcare setting with a new laxative check if the resident suffered from constipation there

and put in steps above to support resident to minimise constipation in the care home setting.

With the Resident:

- Ask the resident (if they are able to communicate) if they have had a bowel movement.
- Normalise discussing bowel movements with residents and encourage them to report if it's not their normal.
- Residents with dementia may present with signs of pain, increased confusion or other challenging behaviour.

Record keeping:

- It is important to remember a stool/hydration chart maybe helpful to understand the resident's full picture however there are negatives to using this method of recording:
  - It can add stigma/ take away from the resident's dignity if a carer is checking the shape and form of the stools
  - These are not always accurately kept up to date
  - Time used recording stool charts for residents who are not at risk of constipation could be spent supporting the resident in assisting with toileting or drinking drinks
- If a stool chart is identified as required, for a short time, then a detailed care plan should be in place see Appendix 1 for examples of care plans

Prescribers' information

Heath conditions

There are some conditions that may increase the risk of constipation. Some of these conditions should be considered and/or treated if the resident is presenting with constipation. Below is a table outlining some examples.

Endocrine and metabolic diseases	Neurological conditions	Structural abnormalities
• Diabetes mellitus (with autonomic neuropathy) • Hypercalcaemia and hyperparathyroidism • Hypermagnesemia (diuretics can cause this) • Hypokalaemia • Hypothyroidism • High plasma urea (kidney failure)	• Autonomic neuropathy • Cerebrovascular disease (stroke and TIA) • Multiple sclerosis • Parkinson's disease • Spinal cord injury, tumours	• Anal fissures, strictures, haemorrhoids • Colonic strictures (for example following diverticulitis, ischaemia, or surgery) • Inflammatory bowel disease • Obstructive colonic mass lesions (for example due to colorectal cancer) • Rectal prolapse or rectocele • Pelvic floor damage or prolapse

Medication Reviews

Constipation can occur due to side-effects of medication or a high Anticholinergic Burden (ACB) score. It is important to note if the constipation has coincided with a new medication being initiated. Below is a list of medications that should be reviewed that are commonly known to cause constipation as a side effect. This list is not exhaustive.

Medication type	**Examples**
Aluminium-containing antacids	Peptac®, Gaviscon®
Supplements	Iron, calcium supplements
Analgesics	Opiates (codeine, buprenorphine etc), NSAIDs
Antimuscarinics/Incontinence medicines	Oxybutynin, procyclidine, solifenacin, mirabegron
Antidepressants	Amitriptyline, clomipramine, dosulepin
Antidiarrheal	Loperamide
Antipsychotics	Quetiapine, risperidone, clozapine, promethazine
Antihistamine	Chlorphenamine, loratadine, cetirizine
Antiepileptics	Carbamazepine, gabapentin, oxcarbazepine, pregabalin, or phenytoin
Antispasmodics	Hyoscine
Calcium channel blockers	Verapamil, diltiazem, amlodipine,
Diuretics	Furosemide, bumetanide, bendroflumethiazide
Proton-pump inhibitors	Lansoprazole, omeprazole

Laxative choices[1]

The dose, choice, and combination of laxatives used depends on the person's symptoms, the desired speed of symptom relief, the response to treatment, and their personal preference [1].

Bulk-forming laxatives such as ispaghula require residents to be taking in adequate (1.5– 2 litres, equal to 6-8 glasses), fluid and should not be taken just before bed. Bulk forming laxatives can take 2-3 days to take effect.

Osmotic laxatives such as lactulose or macrogols work by increasing the fluid in the large bowels. Lactulose also requires adequate fluid intake, whereas the macrogols may not be suitable for all residents especially those who require thickened fluids. Please see MHRA alert. Osmotic laxatives like lactulose can take 2-3 days for their full effects.

Stimulant laxatives such as senna and bisacodyl are faster acting, working within 12 hours. They should be taken in the evenings; all are licenced for short term use only.

Rectal laxatives such as glycerol suppositories are fast acting within a few hours, however these can be quite invasive and undignified. They are licenced for occasional use. They may contain oils which residents can be allergic to.

Appendix 1

Constipation treatment and prevention care plan

[Care home]

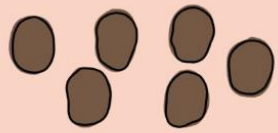
Resident information: Name: DOB: Room: Allergies:	**What does normal look like for the resident:** Frequency of bowel movements: Per Day ☐ Per Week ☐ Normal time of bowel emptying: Normal stool formation (use Bristol stool chart number to indicate):
How does the resident normally communicate: When they need to use the toilet: When they have had a loose bowel movement: When they have had no bowel movement When the resident is uncomfortable	If as required (PRN) laxative is prescribed or utilised: What frequency of bowel movement triggers using PRN laxative: *e.g. if resident passes stool daily if stools have not been passed by day 2 laxative use is commenced* What stool formation is an indication that triggers PRN laxative use: What is the indication of referring to GP: What is the indication to stop using the laxative:

Appendix 2

It's important to know what healthy poo looks like.

NHS

Share this chart with the people you care for to help them identify whether they may be experiencing constipation.

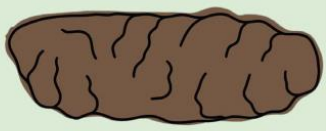


Type 1

Separate hard lumps, like nuts (hard to pass)

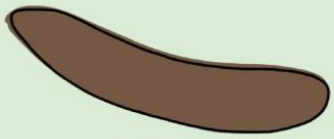
Type 2

Sausage-shaped but lumpy



Type 3

Like a sausage but with cracks on the surface



Type 4

Like a sausage or snake, smooth and soft

Type 5

Soft blobs with clear-cut edges

Type 6

Fluffy pieces with ragged edges, a mushy poo

Type 7

Watery, no solid pieces. Entirely liquid

If a poo does not look like type 3 or type 4 it could be constipation. Contact the GP surgery of the person you are caring for.

Appendix 3

Care home self-check checklist for managing constipation

1. Do your care plans cover toileting habits and what is normal toileting for the resident? Y/N

2. If a resident is identified as requiring constipation prevention and treatment is there a specific care plan in place? (see Appendix 1)

3. Is your care home providing a high fibre diet and a range of drinks appealing to every resident in the care home? Y/N

4. Do you encourage to be mobile? Y/N

5. Does the care home have a laxative such as senna available on their homely medications? Y/N

6. Are your carers confident in supporting residents who have constipation? Y/N

References

1. NICE: CKS Scenario: Constipation in adults. Jan 2024. Accessed Online Scenario: Adults | Management | Constipation | CKS | NICE Aug 2024

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3. Dementia UK. Accessed online https://www.dementiauk.org/wp-content/uploads/dementia-uk-eating-drinking.pdf December 2024

4. The British Dietician Association: Care home digest. (2024). Accessed online Jan 2025 FINAL-BDA-Care-Home-Digest-Edition-1 (1).pdf

5. The British Dietician Association: Hydration in older adults. (2022). Accessed online Jan 2025 https://www.bda.uk.com/resource/hydration-in-older-adults.html

6. NHS England. Accessed on line Jan 2025: Bristol Stool Chart

All Care home good practice guidance can be found on the HWEICB website here: Prescribing Guidance

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