Welcome

Constipation: Unblocking the Problem

We'll be starting shortly! Why not introduce yourselves in the chat?

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If you share our vision, join Bild today to show your commitment to championing the rights of people with learning disabilities, and to gain access a range of resources to support your own practice.

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Enabling people to live happy, healthy lives

12 March

Online

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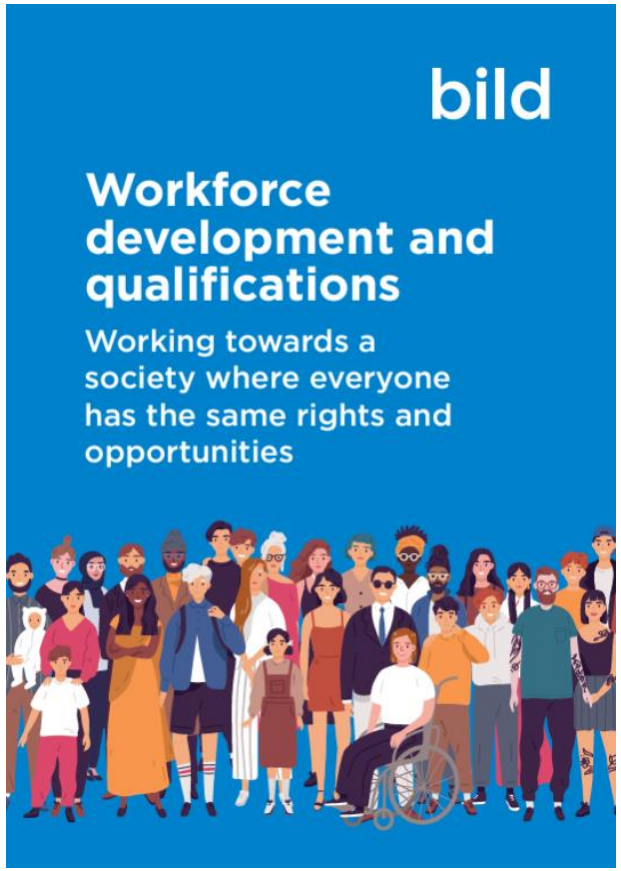


Housekeeping guidance

- Today's webinar is focused on constipation. We will be talking frankly and openly about poo.

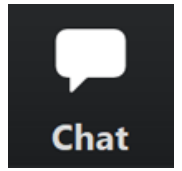
- This webinar is being recorded. The recording will be made available to Bild members after the event.

- To support the running of the webinar, joining audience members' microphones are automatically muted and cameras are switched off.

Housekeeping guidance

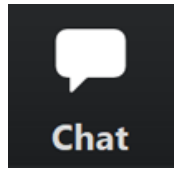
- Please use the Q&A function to ask the host or panellists a question

- You can use the chat function to participate in the conversation



Housekeeping guidance

- There will be some discussion of death in this webinar, including looking at specific deaths caused by constipation. If you need to take some time away to take care of yourself please do.



Agenda

- 12:30 – Introduction
- 12:35 – Flushed with success
- 12:55 – Enhancing the care of people with intellectual disability through research and service development
- 1:15 – Q&A
- 1:30 – Close

Constipation: Unblocking the Problem

Chair: Sarah Leitch

Presentations: **Flushed with Success** (Tracy Pouard, Mark Bowden and Shaun Harvey), **Enhancing the care of people with intellectual disability through research and service development** (Dr Richard Laugharne and Ruth Bishop)

Flushed with Success

Tracy Pouard (Learning Disability Nurse with a special interest in constipation), **Mark Bowden** (Expert by experience and Volunteer with People First), **Shaun Harvey** (Expert by Experience and Volunteer with People First)

Our Proactive Approach:

Mark
Shaun
Tracy

Why we need to keep talking about Poo

Constipation in People with a Learning Disability

Constipation is:

- Not opening your bowels for 3 or more days or at least 3 times in a week

- Chronic constipation -onset of at least 6 months with symptoms consistent over 3 months

Prevalence

25% of adults with a learning disability are prescribed regular laxatives compared with **0.1%** of the general population

Constipation as an issue in reported deaths

January ‘20 to March ‘21 **April ‘21 to March ‘22**

Completed LeDeR reviews – Bristol, North Somerset & South Gloucestershire (BNSSG)

80% **76%**

Constipation

Why is Constipation more Prevalent in People with Learning Disabilities?

Same reasons as other people:

- Poor Diet and Fluid intake
- Reduced Mobility & Lack of Exercise
- Being on a lot of Medications
- Side Effects of Medication

Additionally…

- Cognitive Issues
- Sensory Differences
- Lack of Knowledge/Information
- Ignoring the ‘call to stool’

Additionally…

- Inappropriate Toilet facilities
- Lack of Time or Privacy
- Changes to Support, Routine or Environment

Additionally…

Higher rates of:

Hypothyroidism

Depression

Diabetes

Complicated by:

- Communication Difficulties
- Unusual Presentation of Symptoms
- Diagnostic Overshadowing

Diagnostic Overshadowing

"Where symptoms of physical ill health are mistakenly attributed to either:

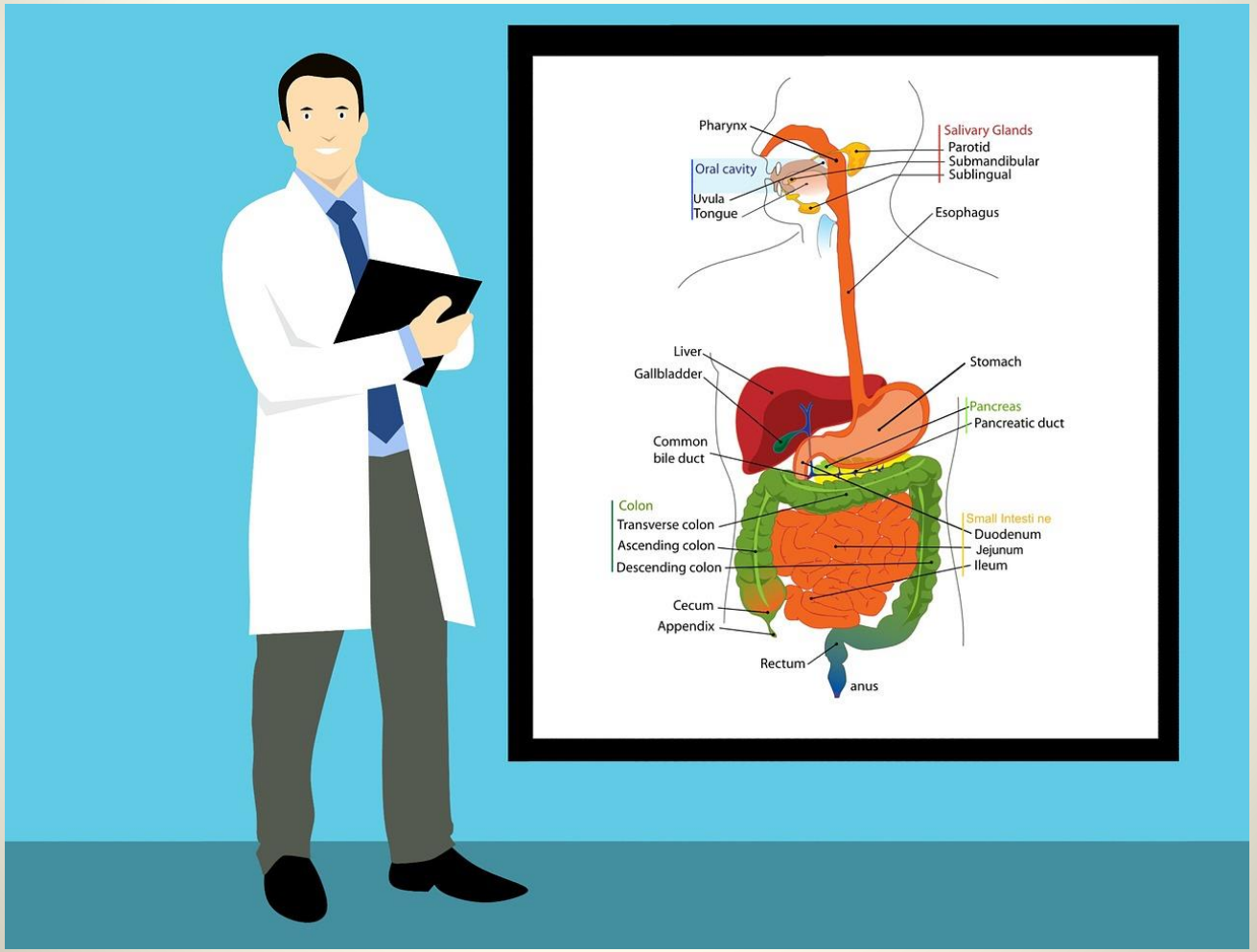
a mental health and/or behavioural problem

or

as being inherent in the person's learning disability"

Emerson & Baines 2010

CASE STUDIES



‘Lily’

Epilepsy – Prescribed Phenytoin

Presented with left sided abdominal pain

Had reported before – but denied having constipation or diarrhoea

‘Lily’

Archived x-ray showed

‘moderate faecal loading’

Lily admitted she did not know what “Constipation” meant

She had been manually evacuating but was too ashamed to tell anyone

‘Alan’

Alan lived alone with daily support

He had significant weight loss & Anaemia

Referred by his GP for a fast track Colonoscopy

‘Alan’

3 months later, Alan has not had the procedure:

Two appointments had been arranged.

Alan sent the hospital transport away both times because he had diarrhoea.

‘Alan’

Alan did not understand the medication taken before the procedure would cause Diarrhoea.

A Lack of ‘Reasonable Adjustments’ resulted in a 14 week delay from referral to diagnosis.

Removing Barriers

What We Do…

Co- Production

Share Experience

Learn Together

Test Recipes

Review Easy Read

Plan Training & Workshops

Raise Awareness

People with Learning Disabilities

Health Professionals

Carers

Inform Professionals

<u>Important to:</u>

Use known/familiar words

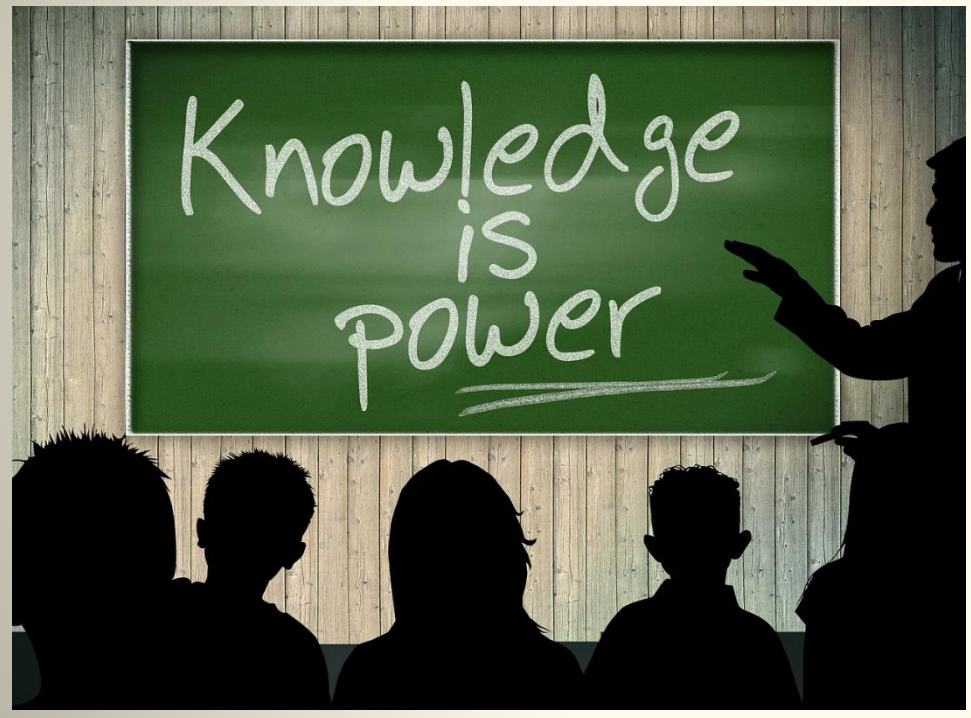
Listen to the person/carer

Inform of medication side effects

Consider risk of Diagnostic Overshadowing

Provide Easy Read

Inform Care Providers



Causes of Constipation

What to look for and Identifying Subtle Signs

Importance of Monitoring

Diet, Fluid and Position

How to Overcome Barriers & Reduce Risks

Introduce the Subject

‘Poo Matters’ Workshop

Thoughts & Feelings

What we know

What is Normal Poo

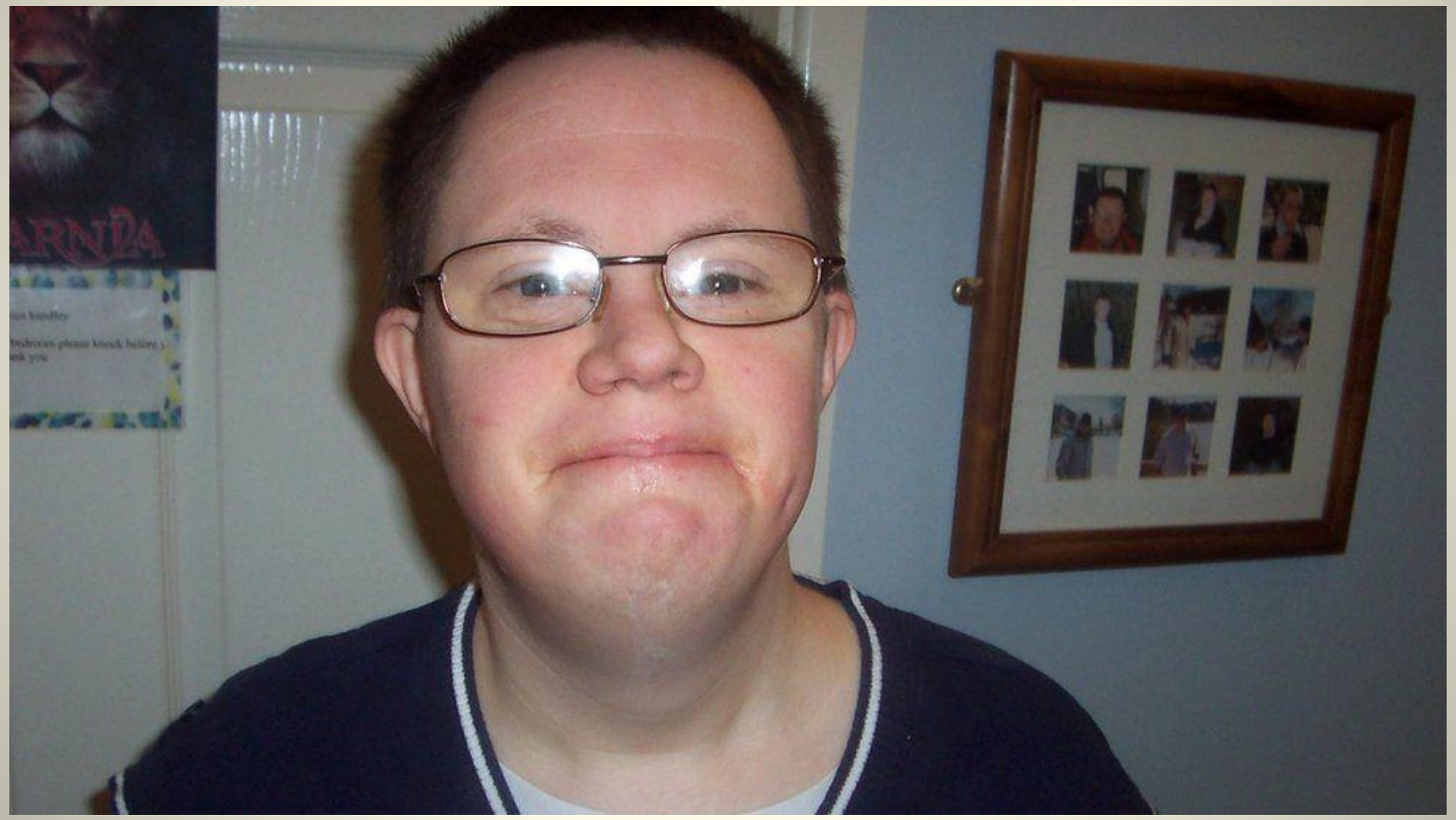
Problems with Poo

What can help

Who can help

Together we can Make a Difference

Richard Handley



Richard

The final slides are shared with permission from Richard's mother, Sheila Handley.

Richard's family fought for an inquest into his death

……. it took 6 years

Richard

Laxatives prescribed from infancy

Hirschsprung's Disease: highly suspected, not confirmed

Bowel problems exacerbated by:

Down's Syndrome
Hypothyroidism
Side effects of medication

Richard

Richard’s symptoms:

Agitation
Restless at night
Declining meals

were consistently attributed to Mental Health problems

Richard

Staff had no training to support and monitor the bowel health of people with learning disabilities

They relied on medical professionals to interpret signs and symptoms

Richard

Staff did not recognise signs as Richard became increasingly impacted:

Faecal smearing

Soiled underwear

Overflow diarrhoea

Distended tummy

Loss of appetite

They did not realise his condition was becoming acute

Richard

Richard died from
a heart attack
after vomiting up,
then inhaling
liquid faeces

Richard

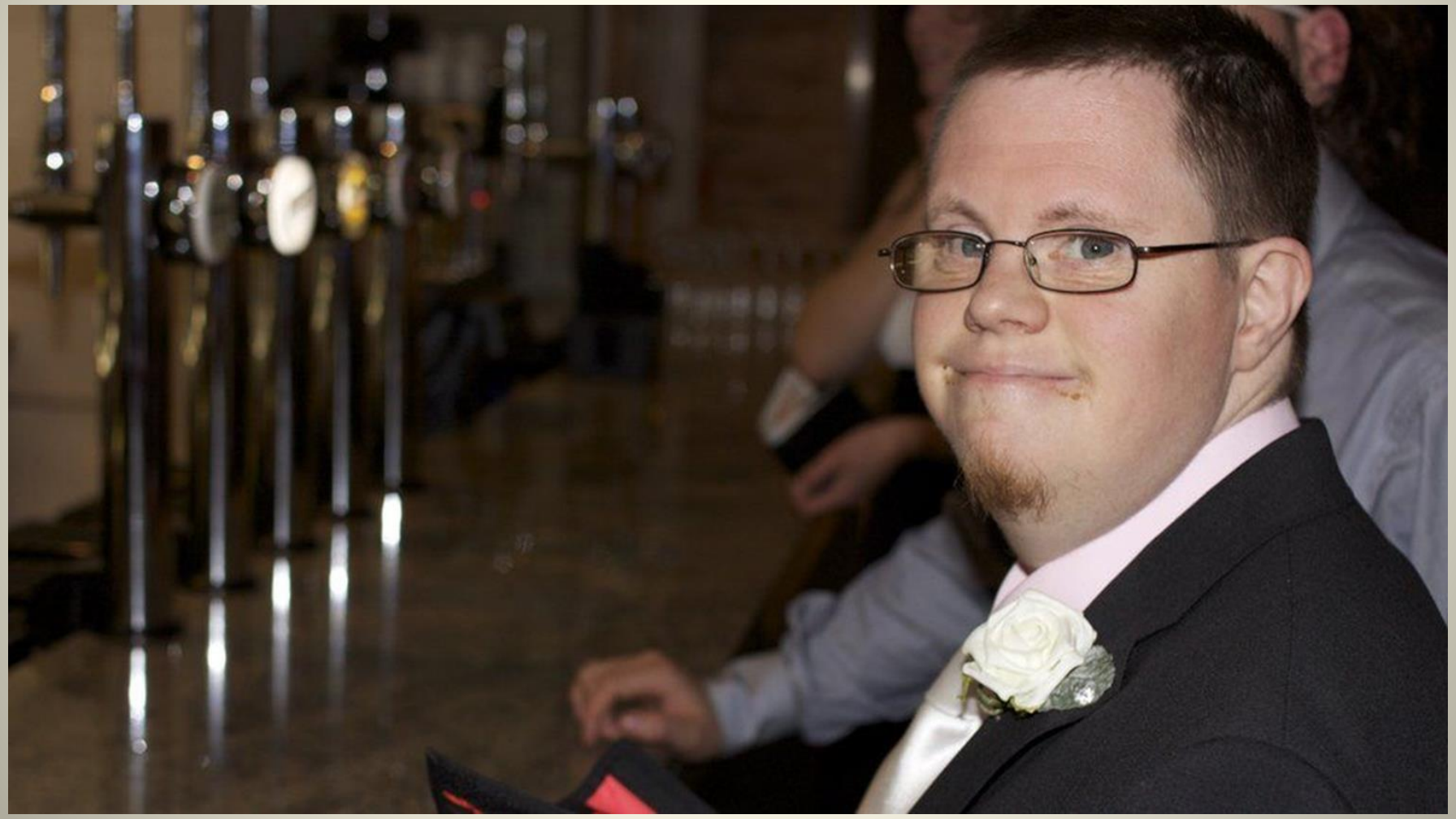
2 days before Richard died:

10kg of faeces were removed from his bowel

Richard

His post-mortem revealed that this was only a small amount of the total impaction

Richard: age at death – 33 years



Thank you for Watching

Acknowledgements:

- **Members of People First**
- **Sheila Handley and Family**
- **Photosymbols**

Contact:

For further information please contact:
Tracy Pouard: learning disability nurse (RNLD):

Tel: 07988 608100
Email: Tracy.pouard@nspf.co.uk

Useful links:

https://bnssg.icb.nhs.uk/wp-content/uploads/2022/06/LeDeR_Annual_Report_2021-22.pdf

https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/constipation-resources/

https://www.england.nhs.uk/publication/constipation-learning-disability-resources/

https://www.ndti.org.uk/assets/files/Constipation_RA_report_final.pdf

https://www.bristol.ac.uk/media-library/sites/sps/leder/ConstipationJANnewsletter.pdf

https://www.nursingtimes.net/roles/learning-disability-nurses/constipation-in-people-with-learning-disabilities-prevalence-and-impact-13-03-2023/

Constipation:

Rome 1V Diagnostic criteria:

2 or more of the following (in 25% of poo's):

- Having to Push or Strain
- Lumpy/hard poo - Type 1&2
- Incomplete feeling after poo
- Feeling of a blockage
- Needing to support pelvic floor to poo
- Need to remove poo with finger
- Less than 3 poos a week
- Poo rarely loose without laxatives

Barriers

- Can they reliably report symptoms?
- Would they be able to spot problem?
- What information been given & how?
- How do they feel talking about poo?

- **If unable or unwilling to talk about:**
  - who else may know & how?
  - How else could signs show?

Changes to Poo

- Lots of poo passed at one time.
- Having a poo more, or less often than is usual.
- Only a little poo passed, even if BSS type within ‘OK’ range.
- Loose or liquid poo – Always consider overflow diarrhoea.

A Change in Usual Routine

Frequent/longer visits to the toilet or avoiding the bathroom.

Loss of bowel or bladder at night or when in bath/shower.

Staying in bed more or longer.

Not wanting to leave home or a familiar place.

Less interest in usual activities.

Declining food/fluid or eating/drinking less than usual

Not wanting to get dressed or wear certain clothes.

** - some people may continue to eat/drink as normal*

Trouble going to sleep, disturbed sleep, restless at night.

A Change of Any Behaviour

Posturing, toe walking, rocking back & forth.	Increased intensity or frequency of known behaviours.	Smearing or soiling (involuntary).	Inserting objects or self-evacuating (poo under fingernails).
Not wanting to sit down (abdominal or anal pain).	Grabbing at or rubbing abdomen – or wanting others to rub their tummy.	General increased irritability and/or anxiety.	Withdrawn or increased clinginess.
	Mood changes – crying, laughing, appearing irrational.	Aggression or frustration – towards self or others	

Other Observations

- Clothes tighter around stomach area (with or without weight gain)
- Acne and skin breakouts
- Brittle nails & thinning hair
- Urinary retention, incontinence, UTI's
- Frequent headaches
- Lower/mid back pain or leg pain (muscle cramps)
- Fatigue and weakness – new or increased
- Reluctance to or difficulty bending, sitting down or walking
- Be aware a person may not show 'guarding'

What is needed?

Don’t Accept	constipation as inevitable or OK.
Changes	to health or a behaviour - always consider constipation.
Consider	link to other health conditions: ie: heart, seizures, pneumonia, bladder infections & retention.
Stay	curious – if something doesn’t seem right, check it out.
Understand	why a person may not report – lack of knowledge, fear & anxiety, past experiences.

Carers as Advocates

Know your person.

Help them speak up or speak up for them.

Use words they know and use.

Be open and positive talking about poo.

Help them to build a toilet routine.

Know why and how to record.

Know what is usual

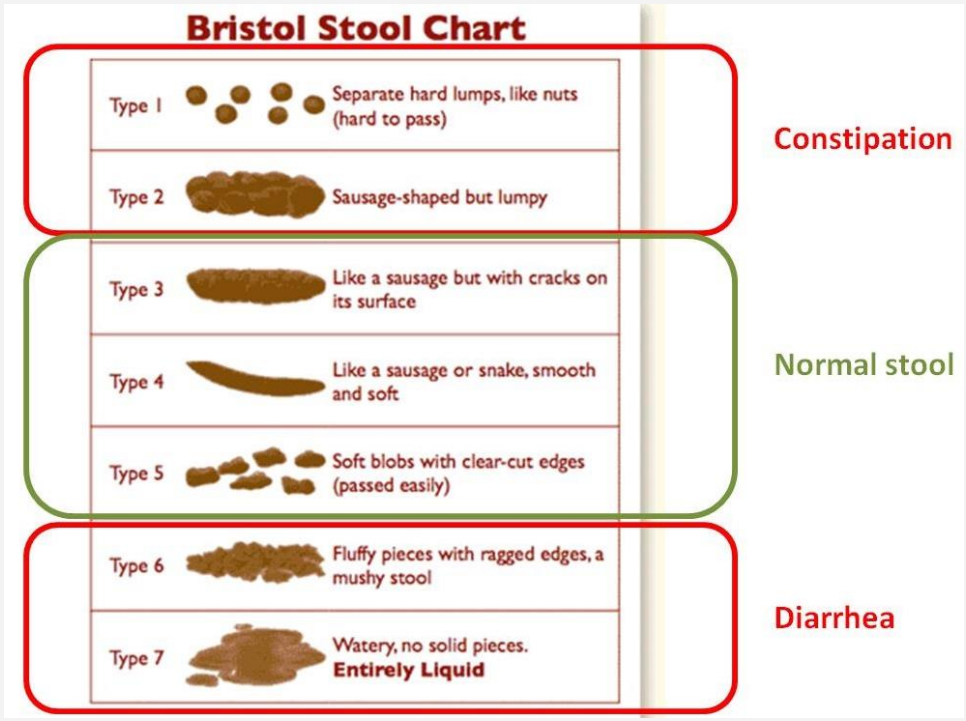
BUT REMEMBER:

'usual may not be normal'

Know when and how to report on.

Work in partnership with professionals.

STAY CURIOUS



Monitoring?
If not, why not?

Is the person ‘independent’ in the toilet?

What does this mean?

Do they understand potential issues and risks?

Could they report problems if they occur?

As a Team

Be	clear on what can make constipation more likely.
Agree	consistent recording of poo size and type.
Record	on a chart, even when bowels not opened.
Seek	guidance and clarity if needed.
Raise	concerns if difficult to monitor or record.
Know	your role in Safeguarding, Duty of Care, use of MCA 2005
Follow	protocols - know action to take and when.

Role of Health Professionals

LISTEN to the person / carers.

CHECK knowledge & understanding.

CONSIDER symptom presentation.

USE familiar language.

EXPLORE - seek more detail.

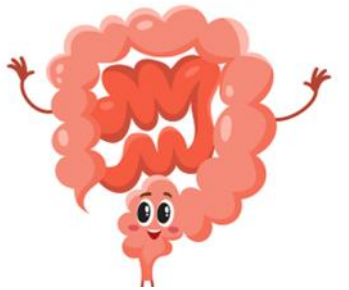
USE visual aids.

INFORM on medication side effects.

GIVE information clearly.

PROVIDE easy read

ASK carers to record.



Total bowel management

Nonpharmacological:

- Diet and Fluid intake
- Mobility & exercise
- Toilet position
- Social & psychological factors
- Toileting routine
- Abdominal massage

Pharmacological:

- Bulk forming laxatives
- Osmotic laxatives
- Stimulant laxatives
- Stool softener laxatives
- Bowel cleansing solutions

“Flushed with Success”

‘Feeling Excited

and Confident after

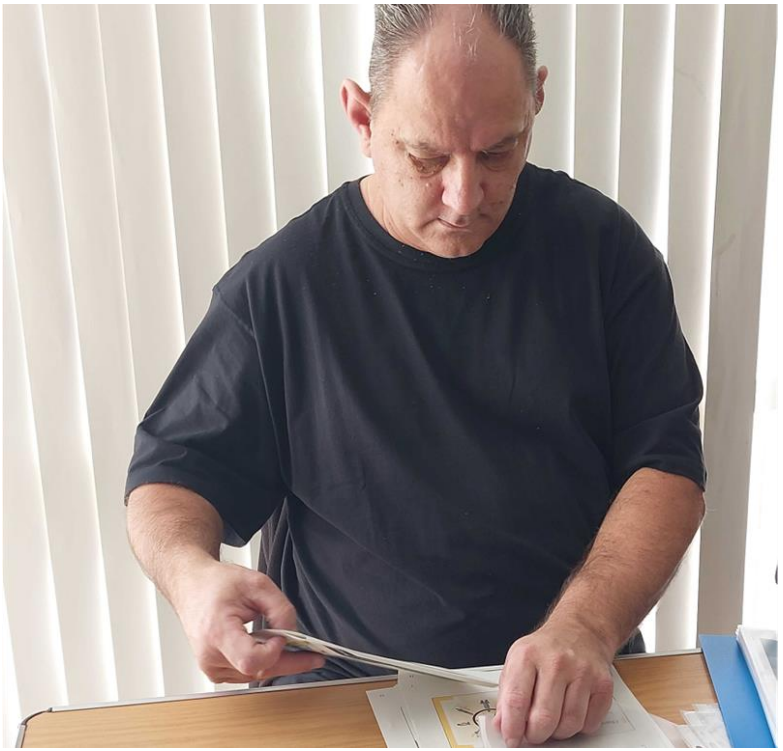
Achieving Something’

Definition from: https://dictionary.cambridge.org/dictionary/english/flushed-with-success

SHAUN:

Knowledge is Power.

I feel AWESOME when I have a poo.



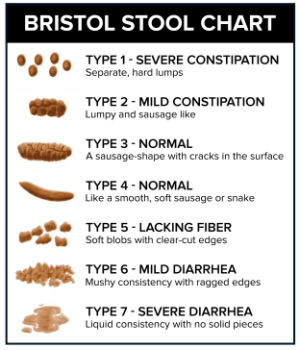
Workshop - Barriers & Solutions

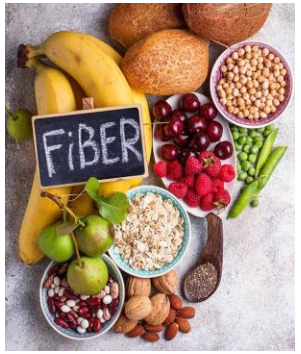
01 Look at Poo

02 Know what is normal

03 Know what causes hard poo

04 Know what and who can help

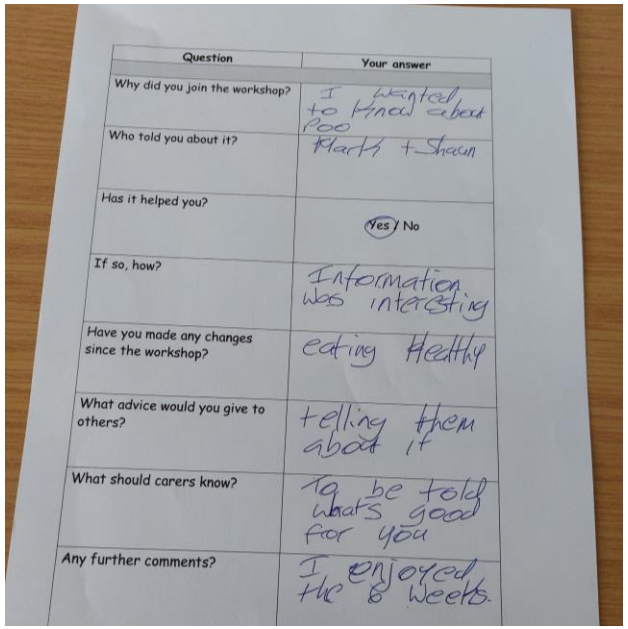




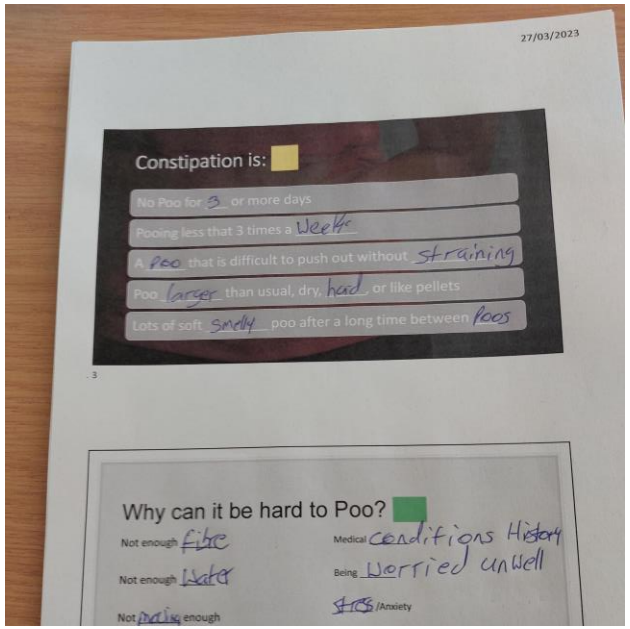
DENISE

Important to talk about:

“So I don’t get poorly with tummy ache”.



Question	Your answer
Why did you join the workshop?	I wanted to know about Poo
Who told you about it?	Mark + Shaun
Has it helped you?	(Yes) / No
If so, how?	Information was interesting
Have you made any changes since the workshop?	eating Healthy
What advice would you give to others?	telling them about it
What should carers know?	To be told what's good for you
Any further comments?	I enjoyed the 8 weeks.



LET'S TALK ABOUT POO

Becky

Not having a Poo:

- Uncomfortable
- Headaches
- Moody

My Advice:

- Go when you need to.
- Have plenty of toilet paper.

Andy

Did not know it was a problem.

I feel able to talk about it now.

Would not have done before.

My Advice:

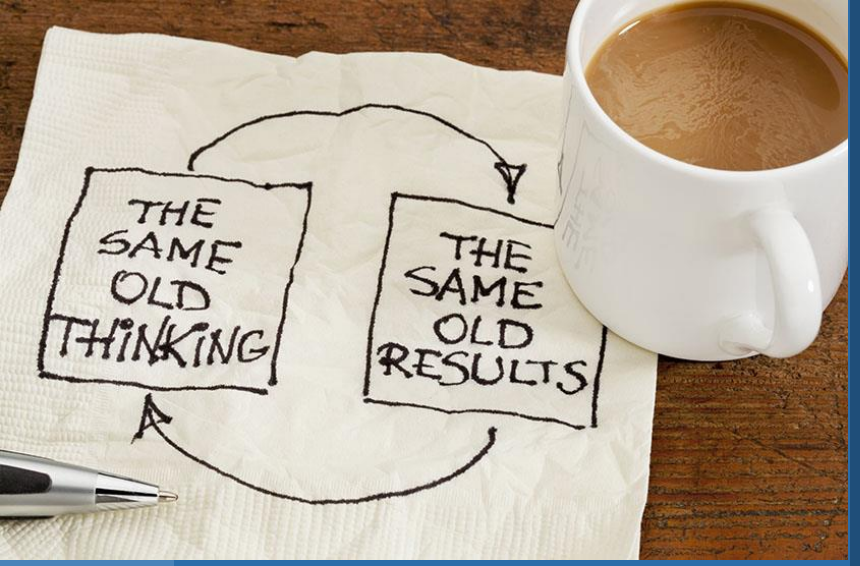
- Talk to someone you trust.
- Carers must know how to support you better.

Lizzie

I get bad headaches

I strain to get it out

- I now know to drink more …



C is not just for Constipation

COMMUNICATE Openly

Look for **CHANGE**

Ensure **CONSISTENCY**

Have a **CARE PLAN**

Always be **CURIOUS**

Avoid **COMPLACENCY**

Be **CREATIVE**

Advocate & **CHALLENGE**

WHAT IS USUAL MAY NOT BE NORMAL

Thank You for Listening

Enhancing the care of people with intellectual disability through research and service development

Dr Richard Laughane (Emeritus Consultant Psychiatrist and Lead for Research, CIDER), **Ruth Bishop** (Researcher and Occupational Therapist, Cornwall Partnership NHS Foundation Trust)

CIDER

CORNWALL INTELLECTUAL DISABILITY EQUITABLE RESEARCH

Enhancing the care of people with intellectual disability through research and service development

working with Plymouth University and Cornwall Partnership Foundation Trust

UNIVERSITY OF PLYMOUTH

NHS
Cornwall Partnership
NHS Foundation Trust

Constipation: unblocking the problem

Dr Richard Laugharne
Emeritus Consultant Psychiatrist & Lead for Research, Cornwall Partnership NHS Foundation Trust, and Visiting Associate Professor in Neuropsychiatry, Peninsula School of Medicine, Plymouth University

Ruth Bishop
Researcher / Occupational Therapist Cornwall Partnership NHS Foundation Trust, and
Honorary Clinical Research Fellow with the South West Clinical School in Cornwall

What factors contribute to constipation in people with intellectual disability?

1. Neurological deficits
2. Difficulty communicating
3. Poor fluid intake
4. Poor diet (may be linked to dysphagia)
5. Poor mobility
6. Side effects of medication

What medications can contribute to constipation?

1. Opiates
2. Antipsychotics
3. Anti-seizure medication (some)
4. Anti cholinergic
5. Antacids
6. Antidepressants
7. Iron & calcium
8. Blood pressure medication

JIDR Journal of Intellectual Disability Research
Published on behalf of mencap and in association with IASSID

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VOLUME PART 2023

Brief Report

Clinical characteristics of people with intellectual disability admitted to hospital with constipation: identifying possible specific high-risk factors

R. Laugharne,[1,2] M. Wilcock,[3] J. Rees,[3] D. Wainwright,[4] N. Newton,[1] J. Sterritt,[1] S. Badger,[1] R. Bishop,[1,2] P. Bassett[5] & R. Shankar[1,2]

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2 *Cornwall Intellectual Disability Equitable Research (CIDER) University of Plymouth Peninsula School of Medicine, Truro, UK*
3 *Pharmacy department Learning Disability Liasion service, Royal Cornwall Hospital NHS Trust, Truro, UK*
4 *Adult Learning Disability Services, Devon Partnership NHS Trust, Exeter, UK*
5 *Statsconsultancy Ltd. Bucks, London, UK*

Inpatient admissions

46 admissions of 43 patients with ID diagnosed with constipation

Exeter and Cornwall admissions 2017-2022

Main findings:

57% had severe ID
37% had epilepsy
41% on antiepileptic medication (only 5% on antipsychotics, 5% on opiates)
Anticholinergic burden not particularly high
45% on laxatives

Hypotheses: people with severe ID, epilepsy and on AEM are particularly vulnerable, and some admissions may be avoidable if laxatives used earlier.

Plans for a case-control study

Chronic constipation in people with intellectual disabilities in the community: cross-sectional study

Richard Laugharne, Indermeet Sawhney, Bhathika Perera, Delia Wainwright, Paul Bassett, Briony Caffrey, Maire O'Dwyer, Kirsten Lamb, Mike Wilcock, Ashok Roy, Katy Oak, Sharon Eustice, Nick Newton, James Sterritt, Ruth Bishop and Rohit Shankar

Background

One-third to half of people with intellectual disabilities suffer from chronic constipation (defined as two or fewer bowel movements weekly or taking regular laxatives three or more times weekly), a cause of significant morbidity and premature mortality. Research on risk factors associated with constipation is limited.

Aims

To enumerate risk factors associated with constipation in this population.

Method

A questionnaire was developed on possible risk factors for constipation. The questionnaire was sent to carers of people with intellectual disabilities on the case-loads of four specialist intellectual disability services in England. Data analysis focused on descriptively summarising responses and comparing those reported with and without constipation.

Results

Of the 181 people with intellectual disabilities whose carers returned the questionnaire, 42% reported chronic constipation. Constipation was significantly associated with more severe intellectual disability, dysphagia, cerebral palsy, poor mobility, polypharmacy including antipsychotics and antiseizure medication, and the need for greater toileting support. There were no associations with age or gender.

Conclusions

People with intellectual disabilities may be more vulnerable to chronic constipation if they are more severely intellectually disabled. The associations of constipation with dysphagia, cerebral palsy, poor mobility and the need for greater toileting support suggests people with intellectual disabilities with significant physical disabilities are more at risk. People with the above disabilities need closer monitoring of their bowel health. Reducing medication to the minimum necessary may reduce the risk of constipation and is a modifiable risk factor that it is important to monitor. By screening patients using the constipation questionnaire, individualised bowel care plans could be implemented.

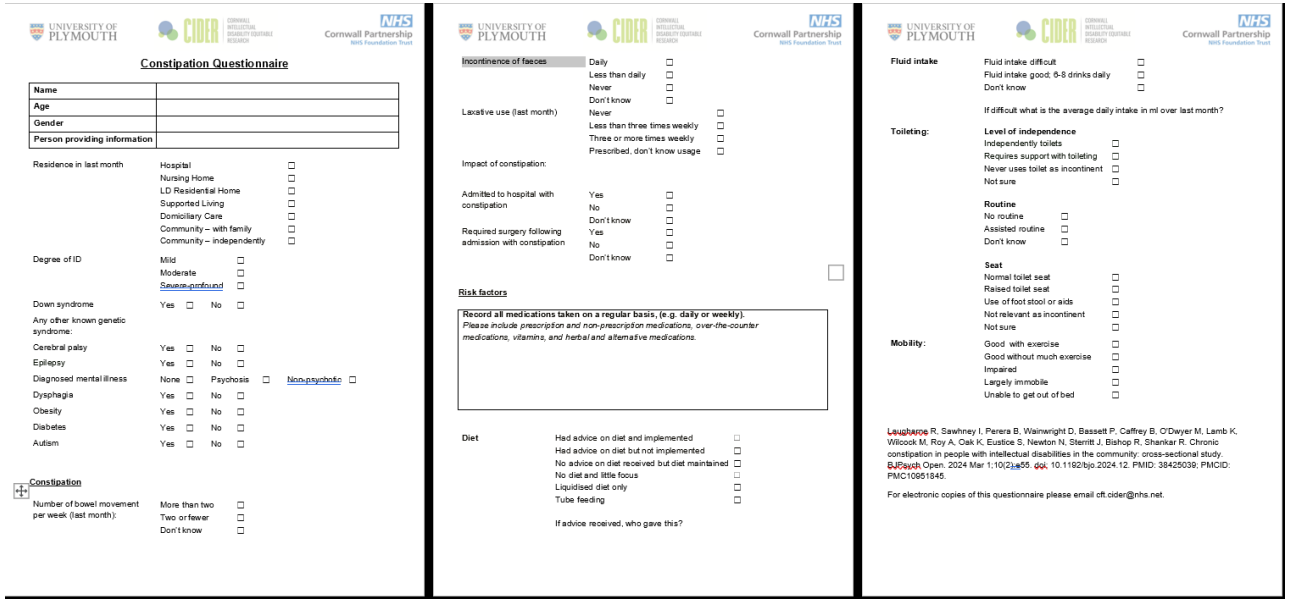
Keywords

Constipation; bowel problems; premature mortality; developmental disabilities; polypharmacy.

People with intellectual disabilities die on average 20 years earlier

Factors associated with constipation in intellectual

Constipation Questionnaire –
background and development



Constipation Questionnaire

Name	
Age	
Gender	
Person providing information	

Residence in last month: Hospital ☐ Nursing Home ☐ LD Residential Home ☐ Supported Living ☐ Domiciliary Care ☐ Community – with family ☐ Community – independently ☐

Degree of ID: Mild ☐ Moderate ☐ Severe-profound ☐

Down syndrome: Yes ☐ No ☐

Any other known genetic syndrome:

Cerebral palsy: Yes ☐ No ☐

Epilepsy: Yes ☐ No ☐

Diagnosed mental illness: None ☐ Psychosis ☐ Non-psychotic ☐

Dysphagia: Yes ☐ No ☐

Obesity: Yes ☐ No ☐

Diabetes: Yes ☐ No ☐

Autism: Yes ☐ No ☐

Constipation

Number of bowel movement per week (last month): More than two ☐ Two or fewer ☐ Don't know ☐

Incontinence of faeces: Daily ☐ Less than daily ☐ Never ☐ Don't know ☐

Laxative use (last month): Never ☐ Less than three times weekly ☐ Three or more times weekly ☐ Prescribed, don't know usage ☐

Impact of constipation:

Admitted to hospital with constipation: Yes ☐ No ☐ Don't know ☐

Required surgery following admission with constipation: Yes ☐ No ☐ Don't know ☐

Risk factors

Record all medications taken on a regular basis, (e.g. daily or weekly).
Please include prescription and non-prescription medications, over-the-counter medications, vitamins, and herbal and alternative medications.

Diet

Had advice on diet and implemented ☐
Had advice on diet but not implemented ☐
No advice on diet received but diet maintained ☐
No diet and little focus ☐
Liquidised diet only ☐
Tube feeding ☐

If advice received, who gave this?

Fluid intake

Fluid intake difficult ☐
Fluid intake good: 6-8 drinks daily ☐
Don't know ☐

If difficult what is the average daily intake in ml over last month?

Toileting:

Level of independence
Independently toilets ☐
Requires support with toileting ☐
Never uses toilet as incontinent ☐
Not sure ☐

Routine
No routine ☐
Assisted routine ☐
Don't know ☐

Seat
Normal toilet seat ☐
Raised toilet seat ☐
Use of foot stool or aids ☐
Not relevant as incontinent ☐
Not sure ☐

Mobility:
Good with exercise ☐
Good without much exercise ☐
Impaired ☐
Largely immobile ☐
Unable to get out of bed ☐

Laugharne R, Sawhney I, Perera B, Wainwright D, Bassett P, Caffrey B, O'Dwyer M, Lamb K, Wilcock M, Roy A, Oak K, Eustice S, Newton N, Sterritt J, Bishop R, Shankar R. Chronic constipation in people with intellectual disabilities in the community: cross-sectional study. BJPsych Open. 2024 Mar 1;10(2):e55. doi: 10.1192/bjo.2024.12. PMID: 38425039; PMCID: PMC10951845.

For electronic copies of this questionnaire please email cft.cider@nhs.net.

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Main findings

42% of this sample suffered from constipation

Higher representation in those suffering from constipation:

- Severe intellectual disability
- Dysphagia
- Cerebral palsy
- Poor mobility
- Polypharmacy (median number of medications 5 vs 3)

Severity of physical and intellectual disability may be significant risk factors

Should we target high risk groups for screening?

BJPsych Open (2024)
10, e84, 1–6. doi: 10.1192/bjo.2024.50

Laxative use in adults with intellectual disabilities: development of prescribing guidelines

Ruth Bishop, Richard Laugharne, Lisa Burrows, CHAMPS Team, Sandra Ward, Sharon Eustice, David Branford, Mike Wilcock, Kirsten Lamb, Alison Tavare, Charlotte Annesley, Stephen Lewis, Vasileios Voulgaropoulos, Faye Sleeman, Beth Sargent and Rohit Shankar

Background

Constipation is overrepresented in people with intellectual disabilities. Around 40% of people with intellectual disabilities who died prematurely were prescribed laxatives. A quarter of people with intellectual disabilities are said to be on laxatives. There are concerns that prescribing is not always effective and appropriate. There are currently no prescribing guidelines specific to this population.

Aims

To develop guidelines to support clinicians with their decision-making when prescribing laxatives to people with intellectual disabilities.

Method

A modified Delphi methodology, the RAND/UCLA Appropriateness Method, was used. Step 1 comprised development of a bespoke six-item, open-ended questionnaire from background literature and its external validation. Relevant stakeholders, including a range of clinical experts and experts by experience covering the full range of intellectual disability and constipation, were invited to participate in an expert panel. Panel members completed the questionnaire. Responses were divided into 'negative consensus' and 'positive consensus'. Members were then invited to two panel meetings, 2 weeks apart, held virtually over Microsoft Teams, to build consensus. The expert-by-experience group were included in a separate face-to-face meeting.

Results

A total of 20 people (ten professional experts and ten experts by experience, of whom seven had intellectual disability) took part. There were five main areas of discussion to reach a consensus i.e. importance of diagnosis, the role of prescribing, practicalities of medication administration, importance of reviewing and monitoring, and communication.

Conclusions

Laxative prescribing guidelines were developed by synthesising the knowledge of an expert panel including people with intellectual disabilities with the existing evidence base, to improve patient care.

Keywords

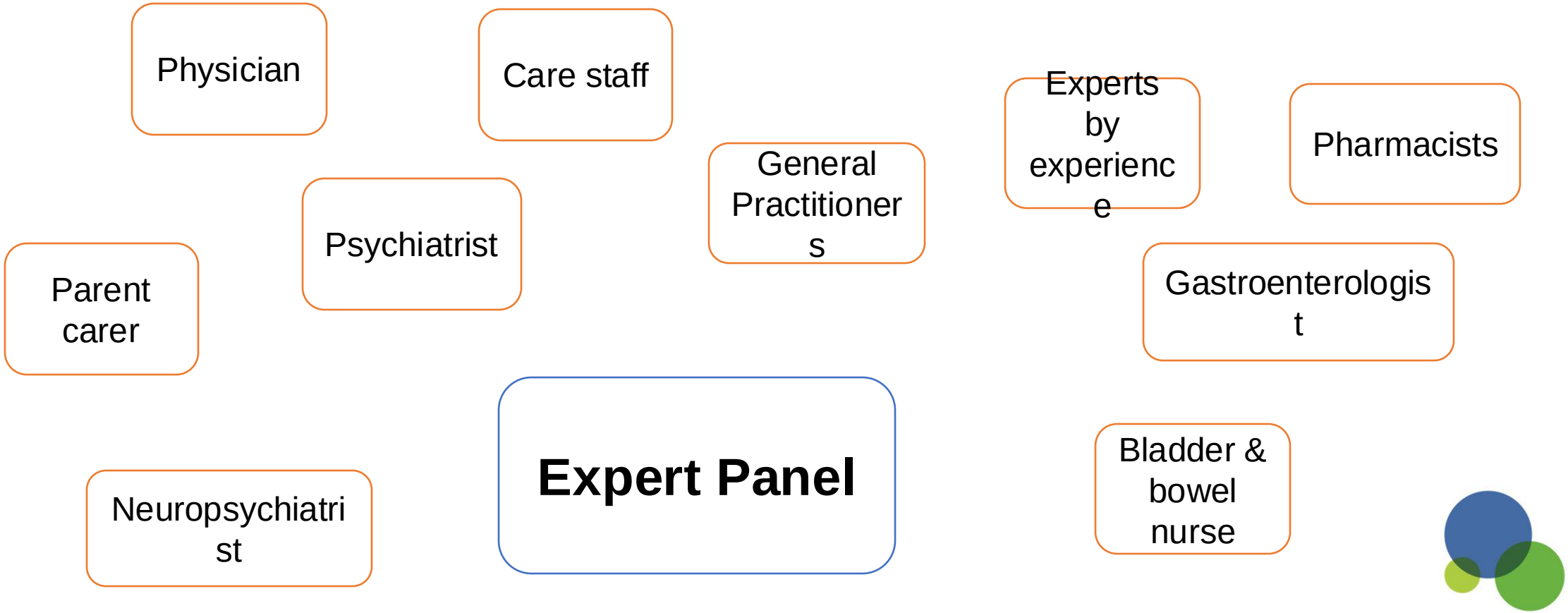
Carers; comorbidity; education and training; intellectual disability; patients.

Bishop R, Laugharne R, Burrows L; CHAMPS Team; Ward S, Eustice S, Branford D, Wilcock M, Lamb K, Tavare A, Annesley C, Lewis S, Voulgaropoulos V, Sleeman F, Sargent B, Shankar R. Laxative use in adults with intellectual disabilities: development of prescribing guidelines. BJPsych Open. 2024 Apr 18;10(3):e84. doi: 10.1192/bjo.2024.50. PMID: 38634310; PMCID: PMC11060064.

Laxative Prescribing Guidelines – *background and development*

- Evidence relating to laxative use with people with ID is limited.
- The literature available suggests poor prescribing practices.
- Aim to develop specific laxative prescribing guidelines for adults with ID.

Laxative Prescribing Guidelines –
background and development



Laxative use in adults with intellectual disability: prescribing guidelines

These general guidelines are written to help in prescribing laxatives, but best practice is for all patients to have an individualised bowel care plan.

What do we mean by constipation?
A change from the person's normal bowel pattern.
Fewer than three bowel movements per week.
Using laxatives three or more times weekly.
Can present with overflow diarrhoea.
How stools look- https://www.bladderandbowel.org/wp-content/uploads/2018/03/BABC002_Bristol-Stool-Chart-Jan-2016.pdf

Red flags
- Severe abdominal pain, faecal vomiting, confusion/delirium: risk of obstruction, needs urgent assessment.
- Change in bowel habit can be secondary to a malignancy: always consider further investigations.

Review medications which can cause constipation:

Iron supplements, antiepileptics, antipsychotics, opiates.
Medications with anticholinergic side effects- e.g. bladder incontinence tablets.
Always discuss with prescriber, may be necessary and therapeutic.

First treatment before laxatives is to increase (if possible):

1. Fluid intake: encourage to drink at least 1.5-2L daily, or 8 cups of water
2. Fibre in diet: encourage fruit, veg, prunes etc. If on parenteral feeding, consider fibre in fluids.
3. Exercise as appropriate.
4. Abdominal massage.
5. Consider opportunities for toileting and toilet positioning.

Key messages

- Use a stepwise approach to prescribing laxatives.
- Use to maximum doses
- **Do not combine laxatives from the same class: combine laxatives from different classes.**
- Continue to focus on fluid, diet and exercise at the same time.
- Refer to specialist if not effective: bowel and bladder nurses, gastroenterologist.

For patients who have good mobility/ambulant: sequentially or in combination

First - BULK FORMING but be careful, may cause obstruction if not drinking enough.

Second - If hard stools use an OSMOTIC
If soft stools use a STIMULANT

Third - Add a laxative from the other class: stimulant to an osmotic or osmotic to a stimulant

Fourth - Consider rectal suppositories/enemas/colonic irrigation.

Practicalities of administration:

- Some laxatives taste unpleasant- consider patient preference.
- Patients with dysphagia may find liquids and tablets difficult to swallow. Note problem of macrogols combining with starch based thickeners.
- Consider rectal suppositories with patient consent or, in the absence of capacity, in patient best interest.

For patients who are <u>of low mobility</u>: sequentially or in combination

First - SOFTENER

Second - If hard stools use an OSMOTIC. If soft stools use a STIMULANT

Third - Add a laxative from the other class: stimulant to an osmotic or osmotic to a stimulant

Fourth - Consider rectal suppositories/enemas/colonic irrigation

Monitoring of prescribing

Importance of regular review including in annual health check.
Consider over-the-counter laxatives.
Community pharmacists are a good resource for advice.
Consider deprescribing.
Consider an Individualised Bowel Care Plan.

Future studies

- Evaluation of using the constipation questionnaire to devise individualised bowel care plans
- Currently being evaluated on 24 patients in 5 inpatient units (mixed NHS and private sector).
- Possibilities: care home study, private sector study

Get in touch

For copies of the Constipation Questionnaire and/or the Laxative Prescribing Guidelines please email us;

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