CONSTIPATION PROTOCOL
Name_________________

The following is intended as a guideline. It does not supersede facility policy, nursing judgment, or physician orders.

Call 911
The following could be signs of a Bowel Obstruction and need immediate attention!!
- If the person appears gravely ill or you are concerned about their immediate health and safety.
- If the person is vomiting material that smells like BM.
- If the person has severe, sharp intermittent or continuous abdominal pain
- If the person has a hard, protruding abdomen.
- Other_______________________________________________________

Sign and Symptoms of Constipation/Impaction
| \- Hard, small, dry stools | \- Smears of feces in undergarments |
| \- Bloating and gas | \- ____ days with no BM. |
| \- Refusing to eat or drink | \- Persons own way of letting you know they are constipated: |
| \- Spending a lot of time on the toilet | \- ________________________________ |
| \- Straining or grunting | \- ________________________________ |
| \- Liquid runny stools | \- ________________________________ |

If noted:
Notify the Nurse____ Supervisor ___ Other___________________________
Document on the Daily Notes___ BM Record___ MAR/TAR*___ Other_____

Documentation Reviewed by___________ Frequency of Review______________

*MAR-Medication Administration  TAR-Treatment Administration Record

Normal Bowel Routine
Describe this persons normal frequency and consistency of BM’s, when and where they normally go, and any special considerations: ________________________________
______________________________
______________________________
______________________________

Monitoring
Document BM’s on the BM Record___ MAR/TAR___ Other___________________________
BM’s documented by Observation___ Self Report___ Other___________________________

Instructions on where to document when out of the home/at work: ________________________________

Documentation Reviewed __________________ Frequency of Review_________________

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### Treatment and Prevention

**Special interventions such as exercise, fluid recommendations.**  
YES___ NO___  See MAR/TAR___

Describe:  

**Dietary Supplements (Fruit Butter, Fiber)**  
YES___ NO___  See MAR/TAR___

Describe:  

**Toileting Schedule/Program**  
YES___ NO___  See MAR/TAR___

Describe:  

**Adaptive Equipment: (Elevated toilet seat, grab bars)**  
YES___ NO___

Describe:  

**Adaptive positioning: (Stander, Prone Positioner, L or R sidelying)**  
YES:___ NO___

Describe:  

**Mobility, clothing, equipment assistance: YES NO**

Describe  

**Hygiene Assistance: (hand-over-hand washing, pericare)**  
YES___ NO___

Describe:  

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### Routine Medications  
YES___ NO___ See MAR/TAR ___

### PRN Medications/Treatments  
YES___ NO___ See MAR/TAR___

Special Instructions for PRN meds:  Such as when to administer, how long to wait for results and who to notify if no results:

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Name_______________________  
Completed by _____________________________  Date____________

Review Dates ___________ ________________ _______________ _______________  

Adapted from Oregon Fatal Four Protocol  
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