Constipation Nursing Care Plan

Patient Information

Full Name: ___________________________________

Date of Birth: ____ / ____ / ________

Gender: _____________________________________

Patient ID: ___________________________________

Contact Number: ______________________________

Email Address: _______________________________

Current Medication Use:_______________

Use of Laxatives or stool softeners:

- ☐ Yes, Amount and frequency: _______________
- ☐ No

Initial Assessment:

Note all stool observations to be made with accordance to the Bristol Stool Scale.

Question	Answer
Patient constipates at any point over the last month	☐ Yes ☐ No
Currently experiencing any significant pain in abdomen, gut, or stomach?	☐ Yes ☐ No
Last bowel motion	Date: Time:
The patient has had fewer than 3 bowel motions per week, over the last month.	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

Over the last month, the patient has had hard or lumpy stool	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always
The patient has had to strain to pass stool.	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always
The patient has experienced a feeling of incomplete passing post-bowel motion.	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always
Patient has experienced a sensation that a bowel motion could not be passed/stuck within the last month.	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always
Within the last month, patient has experienced loose bowel motions without laxative / medical intervention.	☐ Never / rarely ☐ Sometimes ☐ Often ☐ Most of the time ☐ Always

Clinical assessment:

Assessment	Rationale	Notes
Changes in bowels:	The frequency, time of day, pain or straining, and any previous charting of laxative or stool softener.	
Stool characteristics:	By creating a baseline for future comparison, the intervention's effectiveness can therefore be seen. The amount, consistency, color, and odor will be recorded. Utilization of the Bristol Stool Scale for consistent charting between carestaff is key.	
Lifestyle choices:	A sedentary lifestyle and particular diets can trigger constipation and a clearer picture of lifestyle and habits helps with the creation of preventive measures and education in the future to prevent further occurrences.	
Medical history and current medication use:	Medical conditions such as hypothyroidism or use of opioids can cause constipation. By identifying potential root causes, proper intervention can be made.	
Emotional distress:	Depression and anxiety, along with stress, may contribute to constipation.	

Laxative misuse:	Particularly in the older population of patients, excessive use or misuse of stimulant laxatives may be present.	
Cause of pain during stool passing:	Difficulty passing stool may be due to hemorrhoids, rectal fissures, or skin breakdown. Identification of these will assist in appropriate intervention.	

Potential interventions:

Intervention	Notes/ Referrals
• Manual disimpaction • Prescription for laxative or stool softeners and proper use • Lubrication or anesthetic cream • Education around lifestyle changes and high-fiber diets • Promoting adequate fluid intake • Avoiding consumption of gastrointestinal aggravators such as alcohol and caffeine • Encouragement for daily tracking of it is a chronic issue • Education on abdominal massage	

Tracking for Intervention success:

Date / Time	Type	Intervention use

Physician's Notes and Recommendations

Physician's Signature: ______________________________ Date: ____ / ____ / _____