**Constipation and Bowel Obstruction Healthcare Plan**

| **Name:** | FirstName LastName | | | | **Date of Birth:** | | Type DOB Here | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **These are my diagnoses related to constipation and bowel obstruction:** | | | List all diagnoses related to constipation and bowel obstruction, or indicate if there are none. | | | | | |
| **I am allergic to these things:** | | | List all known allergies and sensitivities, or indicate if there are none. | | | | | |
| **The goal of this Healthcare Plan is:** | | | I will not experience any constipation or bowel obstruction for ## days/months.  I will drink enough water each day to remain free of constipation and bowel obstruction for the duration of the ISP year.  I will walk ## minutes per day for the duration of the ISP year.  Describe any other goal related to managing my constipation and preventing bowel obstruction. | | | | | |
| **Progress in the past year:** | | | What has my status with constipation and bowel obstruction over the past year been as compared with the year prior? List any incidents of bowel obstruction this year, or indicate if there have been none. | | | | | |
| **As of the date this plan was signed, I have bowel movements about:** | | | Two or more times a day | Once a day | | Once every other day | | Less than three times a week |
| **This is my status with managing my toileting needs:** | | | I am continent of bowel and bladder and assistance is not required or appreciated. | | | | | |
| I am usually continent or bowel and bladder, but need help such as transfer assistance or help with hygiene. | | | | | |
| I am usually incontinent of bowel and/or bladder and wear briefs. | | | | | |
| I am fully incontinent of bowel and/or bladder and require total physical assistance in this area. | | | | | |
| **In an EMERGENCY**  **Call 911 IMMEDIATELY IF I:**  **🡪 Vomit a substance that smells like feces**  **🡪 Lose consciousness (become unresponsive)**  **🡪 Have low blood pressure and/or very rapid pulse**  **🡪 Have a very distended or bloated abdomen**  **🡪 Describe any additional instructions here** | | | | | | | | |
| **DO NOT MAKE NOTIFICATION PHONE CALLS UNTIL**  **I AM STABLE AND OR EMERGENCY SERVICES HAVE BEEN NOTIFIED.** | | | | | | | | |
| **When I have am constipated, this is what usually happens:** | | | I do not have bowel movements for ## days or longer.  I do not pass gas.  I have leakage (passing small amounts of watery stool).  I have abdominal cramps, sometimes coming in waves.  My stomach is bloated (distended).  My abdomen is hard or solid to the touch.  I have a seizure.  Other Describe any other things I do or that happen to me when I become constipated, or indicate if there are none. | | | | | |
| **Supporters should be aware that some conditions and circumstances make it more likely that I will become constipated or develop a bowel obstruction:** | | | I cannot walk around on my own.  I need a lot of help eating and drinking.  I do not get enough fiber in my diet.  I do not drink enough fluids.  I have diabetes.  I have a condition that affects my muscle strength, such as cerebral palsy or Parkinson’s disease. Specify condition here, or indicate if there is none.  I take medicine with a side effect of constipation.  Other Describe any other things that make constipation/bowel obstruction more likely. | | | | | |
| **This is how to help make sure I don’t get constipated:** | | | Make sure that I am repositioned frequently, at least every ## hours  Help me walk around my house or neighborhood.  Make sure I receive my medications on time.  Help me get enough to drink.  Encourage me to eat foods that have a lot of fiber.  When I have a bowel movement, write it down.  If I have bowel movements that look like Types 1, 2, or 3 on the Bristol Stool Chart (below), let the nurse know.  Other Describe any other supports I need to prevent constipation, or indicate if there is none. | | | | | |
| **When I am constipated, this is the support I need to help me recover:** | | | Notify the nurse when I have not had a bowel movement in indicate ## days or ## hours  Follow the instruction given to me by the nurse for treatment of constipation.  Other Describe any other things that need to be done when I am showing signs of constipation. | | | | | |
| **Documentation:** | | Describe the things that supporters should write down and where they should write them down, including reference to Bristol Stool Chart (below). | | | | | | |
| **Nursing Intervention:** | | Describe those things that must be done by the nurse relative to bowel obstruction and constipation, including those non-delegable duties listed in O.C.G.A. § 43-26-32 or HRST Q Score. | | | | | | |

**Signature of RN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RN Typed Name and Agency

This healthcare plan is reviewed at least annually and promptly revised as my diagnosis/risk status changes.

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

RN Typed Name and Agency

**Review date: \_\_\_\_\_\_\_\_ Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan revision required?** Yes No

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