Standardised care process (SCP): constipation

health

Topic

Prevention, assessment and management of constipation

Objective

To promote evidence-based practice in the prevention, assessment and management of constipation

Rationale

Constipation is a common problem in older people (RNAO, 2005). Intervention can reduce the likelihood of constipation and associated complications and discomfort occurring and appropriate management can improve resident outcomes.

Definition

Constipation: 'difficulty with defecation and infrequent bowel movements over an extended period of time' (JBI, 2008 p1). There is no objective definition of constipation because of great individual variation in normal bowel habit. The term implies a diminished frequency of bowel motions and/or the passage of small hard stools. The normal frequency of bowel motions in Western countries varies from three times per day to twice per week.

A person may complain of constipation if:

- defecation occurs less frequently than usual
- stools are harder than usual
- defecation causes straining
- there is a sense of incomplete evacuation (Therapeutic Guidelines Limited, 2006).

Team

Manager, RNs, ENs, PCAs, resident and/or family, GP, activity staff, physiotherapist, dietician

Evidence base for this SCP

Department of Veterans' Affairs 2007, 'Constipation: a quality of life issue for veteran patients'. *Therapeutic brief*, retrieved 5 March 2012, <https://www.veteransmates.net.au/VeteransMATES/documents/module_materials/M10_TherBrief.pdf>

Joanna Briggs Institute (JBI) 2008, *Management of constipation in older adults*. Best Practice Information Sheet 12(7), JBI, Adelaide.

McKay SL, Fravel M and Scanlon C, 2009, *Management of constipation*, University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination, Iowa City.

Registered Nurses Association of Ontario (RNAO) (2005), *Prevention of constipation in the older adult population,* Ontario: RNAO.

Therapeutic Guidelines Limited 2006, *Therapeutic guidelines gastrointestinal*, Therapeutic Guidelines Limited, Australia.

Brief SCP: constipation

Prevention	• On admission conduct bowel assessment • Implement the following interventions to lessen the likelihood of constipation occurring
Recognition and assessment	• Identify possible constipation by presence of symptoms • Conduct bowel assessment
Interventions	• Seek medical review for possible underlying cause • Enemas, suppositories or osmotic aperients • Promote regular bowel actions through development and implementation of an individualised bowel management plan • Implement an individualised bowel management plan
Referral	• GP for advice and medication review if constipation is not resolved • Continence advisor if available • Dietician for assessment and advice • Acute services if unresolved and severe (for example, acute abdominal pain)
Evaluation and reassessment	• Ongoing monitoring of frequency and character of bowel stools using Bristol Stool Chart and a bowel chart • Ongoing monitoring of diet and fluid intake, exercise patterns, functional ability and the environment
Resident involvement	• Education regarding diet, fluids and participation in exercise • Choices regarding diet, fluids and exercise • Involvement in treatment options
Staff knowledge and education	• Physiology of constipation • Prevention of constipation • Management options

Full SCP: constipation

Prevention

On admission conduct bowel assessment including:

- normal bowel pattern:
  - usual time, frequency
  - character of stool
  - history of constipation and/or faecal incontinence
  - ability to sense urge to defecate
  - any straining to start and finish defecation
  - any history of incomplete evacuation
- medical history
- current medications including laxatives and all over the counter medicines
- resident's beliefs in relation to bowel movements
- strategies used to encourage bowel movements (for example, laxatives, prunes, bran) and the effectiveness of these strategies
- diet (for example, preferred foods, fibre intake)
- type of fluids preferred and usual daily intake
- functional ability, particularly ability to access and use toilet (for example, can the resident get to the toilet, adjust clothing, are they able to sit on the toilet at its normal height?)
- cognitive status; particularly ability to communicate needs and to follow simple instructions
- maintain a seven-day bowel 'diary'.

Conduct physical assessment of the abdomen and where indicated the rectum, including:

- abdominal muscle strength
- presence of abdominal masses
- presence of bowel sounds
- presence of faecal impaction
- presence of haemorrhoids
- presence of intact anal reflex.

Implement the following interventions to lessen the likelihood of constipation occurring:

- check medications to assess their potential for causing current or future problems (some medicines can increase the likelihood of constipation occurring, for example, opioid analgesics, antidepressants, anticholinergics)
- encourage increased fluid intake if fluid restriction is not in place
- gradually introduce and increase fibre intake to 21–25 grams/day
- promote regular toileting regime based on resident's usual pattern
- ensure privacy: visual and auditory
- position in squat position (for example, sitting on toilet or on side with knees bent if bed bound or providing a foot stool to raise and support feet if toilet is too high)
- exercise as able, for example, walking for those who are able, bed-based mobility exercises for those not able to walk (for example, active and/or passive exercise, pelvic tilt, low trunk rotation and single leg lifts, massage)
- ongoing monitoring of bowel actions for frequency, character
- episodes of constipation/faecal incontinence using an appropriate assessment tool such as the Bristol Stool Chart
- monitor for episodes of constipation/faecal soiling and use of laxative interventions (oral and rectal)
- monitor the resident's satisfaction with bowel patterns.

Recognition and assessment	Constipation should be suspected if the resident: • complains of rectal pain, nausea or vomiting when attempting to open bowels • shows signs of straining when attempting to open bowels • complains of incomplete emptying after opening bowels • passes hard stools • complains of abdominal pain or discomfort • does not open bowels for longer than his/her normal time period • displays unmet need behaviour or pre-existing unmet need behaviour worsens. Conduct bowel assessment including: • frequency and character of stool • changes to medical history • current medications including laxatives • changes to diet • type of fluids preferred and usual daily intake • changes to functional ability particularly ability to access and use toilet (for example, can the resident get to the toilet, adjust clothing, are they able to sit on the toilet at its normal height?) • changes in environment particularly those affecting privacy (for example, are they now sharing a bathroom?). Conduct physical assessment of the abdomen and if indicated the rectum including: • abdominal muscle strength • presence of abdominal masses • presence of bowel sounds • presence of faecal impaction • presence of haemorrhoids • presence of intact anal reflex.
Interventions	The aim of intervention is to restore regular bowel movements. The choice of interventions should be individualised to the resident's needs and situation. • Acute constipation: enemas, suppositories or osmotic aperients • Stimulant and stool softener recommended if constipation is caused by opiate medicines • Chronic constipation: bulking agents, increased fibre • Promote regular bowel actions through development and implementation of an individualised bowel management plan, which may include: – increasing fluid intake – increasing intake of foods such as dates, prunes, figs and high fibre foods (note that increasing fibre intake without increasing fluid intake may increase likelihood of faecal impaction occurring in immobile older people) – possible ongoing use of bulking agents, osmotic agents or enemas and suppositories – implementing prevention strategies as above.

Referral	• GP for advice and medication review if constipation is not resolved • Continence advisor if available • Dietician for assessment and advice • Physiotherapist for mobility assessment and development of exercise program • Acute services if unresolved and severe (for example, acute abdominal pain)
Evaluation and reassessment	• Ongoing monitoring of frequency and character of bowel stools using the Bristol Stool Chart and a bowel chart • Ongoing monitoring of diet and fluid intake, exercise patterns and functional ability
Resident involvement	• Education regarding diet, fluids and participation in exercise • Choices regarding diet, fluids and exercise • Involvement in treatment options
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