Constipation

Standardised care process

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

Why preventing and managing constipation is important
Constipation is a common problem in older people (Chen 2013). Intervention can reduce the likelihood of constipation and associated complications and discomfort occurring, and appropriate management can improve resident outcomes.

Definitions

**Functional constipation:** persistent difficult or seemingly incomplete defecation and/or infrequent bowel movements (once in every three to four days or less) in the absence of alarm symptoms or secondary causes (World Gastroenterology Organisation 2010).

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 three times 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 (Registered Nurses’ Association of Ontario 2011).

**Standardised care process (SCP):** This has been developed for the Department’s Strengthening Care Outcomes for Residents with Evidence (SCORE) initiative through comprehensive review of evidence and consultation with public sector residential aged care stakeholders and experts to mitigate significant clinical risk in residential aged care services.

**Clinical risk:** is where action or inaction on the part of the organisation results in potential or actual adverse health outcome on consumers of health care (Department of Health, 2012, p5).

Care team
Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), general practitioner (GP), activity staff, physiotherapist, dietitian, residents and/or family/carers.

Acknowledgement
This SCP has been developed by the Australian Centre for Evidence Based Care, La Trobe University for the Department of Health and Human Services based on the best available evidence.
## Constipation: brief standardised care process

| Prevention                                    | • Conduct bowel assessment on admission.  
|                                              | • Implement the following interventions to lessen the likelihood of constipation occurring. |
| Recognition and assessment                   | • Identify residents with risk factors that contribute to constipation.  
|                                              | • Conduct bowel assessment.  
|                                              | • Identify possible constipation by presence of symptoms. |
| Interventions                                | • The choice of interventions should be individualised to the resident’s needs and situation.  
|                                              | • Seek medical review for possible underlying cause.  
|                                              | • Use dietary, behavioural and lifestyle changes as first line response.  
|                                              | • Use bulking agents, osmotic and stimulant aperients as required.  
|                                              | • Promote regular bowel actions through development and implementation of an individualised bowel management plan.  
|                                              | • Implement prevention measures for all residents at risk of constipation. |
| Referral                                     | • GP for advice  
|                                              | • Pharmacist for medication review if constipation is not resolved  
|                                              | • Continence advisor if available  
|                                              | • Dietitian 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. |
| 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 and management of constipation.  
|                                              | • Early identification of residents at risk of constipation.  
|                                              | • Prevention of constipation. |
### Constipation: full standardised care process

<table>
<thead>
<tr>
<th>Recognition and assessment</th>
<th>Identify residents with risk factors that contribute to constipation:</th>
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<tbody>
<tr>
<td></td>
<td>• admission into residential aged care</td>
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<td>• decreased mobility and inactivity</td>
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<td>• chronic illness</td>
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<td>• dementia</td>
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<td>• multiple medicines</td>
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<td>• diminished intake of fibre and fluids</td>
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<td>• painful ano-rectal disorders (haemorrhoids, anal fissure)</td>
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<td>• female gender</td>
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<td>• lack of privacy</td>
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On admission conduct bowel assessment:

- exclude secondary causes of constipation
  - check individual medicines and polypharmacy 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)
  - conditions associated with constipation (neurological, endocrine/metabolic, gastrointestinal disorders, myopathy)
  - recent onset accompanied by alarm symptoms of fresh blood in stool, family history of bowel cancer, recent and rapid weight loss

- establish usual bowel pattern (as defined by the resident)
- establish the resident’s beliefs in relation to bowel movements
- establish current bowel performance: maintain a seven-day bowel ‘diary’ or charting
  - usual time, frequency
  - character of stool (see: Bristol Stool Chart), mucus
  - 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
  - symptoms of bloating or pain on or between bowel movements
- medical history
- current medications including laxatives and all over-the-counter medicines
- 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
- environment, particularly that affecting privacy (for example, a shared bathroom).
## Constipation: full standardised care process

### 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.

Constipation should be suspected if the resident complains of two or more of the following symptoms for at least 25 per cent of bowel actions:
- 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 behavioural and psychological symptoms of dementia (BPSD) or pre-existing BPSD worsens
- displays small frequent amounts of loose stool (overflow).

### Interventions

The aim of intervention is to restore regular bowel actions (frequency, consistency and ease of passage). The choice of interventions should be individualised to the resident’s needs and situation.

- **Recent onset with alarm symptoms:** seek medical advice for further investigation and screening for colon cancer.
- **Constipation due to secondary causes:** as per chronic constipation.
- **Faecal impaction:** seek medical advice.
- **Chronic constipation:**
  - changes to diet, behaviour and lifestyle
  - bulking agents, increased fibre are indicated for mobile residents
  - osmotic and stimulant aperients are indicated for bed-bound residents.
- **Medication review.**
- **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.

Once constipation has been resolved, implement prevention strategies.
### Constipation: full standardised care process

| Prevention | For residents with resolved constipation or who have been identified as at risk of constipation, the following interventions will help prevent constipation in the future.  
Dietary:  
- Encourage increased fluid intake (1,500–2,000 ml per day) if fluid restriction is not in place  
- Gradually introduce and increase fibre intake to 21–25 grams/day through dietary or supplemental sources as tolerated in mobile residents.  
- Consider use of probiotic supplementation.  
Behavioural:  
- Ensure dignity and privacy (visual and auditory) are safeguarded.  
- Promote regular toileting regime based on resident’s usual pattern.  
- Squat positioning (sitting on toilet: knees above the hips, with a foot stool to raise and support feet if required; if bed-bound: lying on left side with knees bent towards the abdomen).  
- Give the resident adequate time on the toilet.  
- 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.  
Lifestyle:  
- Exercise as able; 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).  
- Where possible replace medicines that cause constipation with non-constipating alternatives. |
| --- | --- |
| Referral | • GP for advice  
• Medication review if constipation is not resolved  
• Continence advisor if available  
• Dietitian 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. |
| Staff knowledge and education | • Physiology of constipation.  
• Early identification of residents at risk of constipation.  
• Prevention of constipation.  
• Management options. |
Evidence base for this SCP


Registered Nurses’ Association of Ontario 2011, Prevention of constipation in the older adult population, RNAO, Ontario.

Therapeutic Guidelines Limited 2011, Therapeutic guidelines gastrointestinal, Therapeutic Guidelines Limited, Australia.


Important note: This SCP is a general resource only and should not be relied upon as an exhaustive or determinative clinical decision-making tool. It is just one element of good clinical care decision making, which also takes into account resident/patient preferences and values. All decisions in relation to resident/patient care should be made by appropriately qualified personnel in each case. To the extent allowed by law the Department of Health and Human Services and the State of Victoria disclaim all liability for any loss or damage that arises from any use of this SCP.

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