

Constipation

Standardised care process



Objective

To promote evidence-based practice in the prevention, assessment and management of constipation for older people who live in residential care settings.

Why the prevention and management of constipation is important

Constipation is a common problem in older people (Bellman 2017). Intervention can reduce the likelihood of constipation and associated complications and discomfort occurring, and appropriate management can improve resident outcomes.

Definitions

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 (RNAO 2011).

Team

Manager, registered nurses (RNs), enrolled nurses (ENs), personal care attendants (PCAs), leisure and lifestyle staff, general practitioner (GP), allied health professionals (such as a physiotherapist, occupational therapist and exercise physiologist), residents and/or family/carers.

Acknowledgement

This standardised care process (SCP) has been developed for public sector residential aged care services (PSRACS) by the Australian Centre for Evidence Based Care (ACEBAC) at La Trobe University through the Department of Health and Human Services Strengthening Care Outcomes for Residents with Evidence (SCORE) initiatives. This SCP is one of a series of priority risk areas reviewed based on the best available evidence in 2017.



Brief standardised care process

Recognition and assessment

- Identify residents with symptoms that are indicative of possible constipation.
- Conduct a bowel assessment.
- Undertake a physical examination of the abdomen and, where indicated, a digital rectal examination.

Interventions

The choice of interventions should be individualised to the resident's needs and situation.

- Seek medical review for a possible underlying medical cause.
- Consider dietary, behavioural and lifestyle changes as the first-line response.
- Prescribe bulking agents, osmotic, stimulant and non-bulk-forming aperients as required.
- Promote regular bowel actions through an individualised bowel management plan.
- Introduce prevention measures for all residents at risk of constipation.

Referral

- GP
- Medication review
- Continence advisor
- Dietitian
- Physiotherapist
- Acute services

Evaluation and reassessment

- Ongoing monitoring of bowel actions for frequency and character of bowel stools and episodes of constipation/faecal incontinence
- Monitor for episodes of constipation/faecal soiling and use of laxative interventions
- Ongoing monitoring of diet and fluid intake, exercise patterns, functional ability
- Monitor the resident's satisfaction with bowel patterns

Resident involvement

- Education regarding dietary fibre, fluids and participation in exercise
- Choices regarding dietary fibre, fluids and exercise
- The role of toileting habits in maintaining bowel regularity
- Involvement in treatment options

Staff knowledge and education

- Physiology of constipation
- Early identification of residents at risk of constipation
- Prevention of constipation
- Management options
- Physical examination of the abdomen



Full standardised care process

Recognition

Constipation should be suspected if the resident exhibits or complains of the following symptoms:

- straining when attempting to open their bowels
- lumpy or hard stools
- abdominal pain, cramping, discomfort (bloating or distention)
- decreased frequency of usual bowel opening
- rectal pain or presence of blood when attempting to open the bowels
- nausea or vomiting when attempting to open the bowels
- feeling of incomplete emptying after opening the bowels
- increased confusion or responsive behaviours, or pre-existing behaviour worsens
- displays small frequent amounts of loose stool (overflow).

Assessment

A bowel assessment should be completed on admission and whenever constipation is suspected. The assessment should:

- exclude medical conditions associated with constipation (neurological, endocrine/metabolic, gastrointestinal disorders, myopathy and painful anal rectal disorders)
- review medication history including prescribed, over-the-counter, complementary and alternative medicines to determine the potential for causing current or future problems
- identify recent-onset constipation accompanied by alarm symptoms of fresh blood in the stool, recent and rapid weight loss and any family history of bowel cancer
- establish a history of constipation and/or faecal incontinence or incomplete evacuation
- establish the resident's usual bowel patterns and habits, and their beliefs in relation to these habits
- identify any recent variations that could contribute to changed bowel habits such as recent illness, new medication, change to diet/ fluid intake or haemorrhoids
- establish current bowel performance by maintaining a seven-day bowel 'diary' or charting to include the following information:
 - usual time, frequency

- character of stool (amount, colour, consistency and presence of mucus) – the Bristol Stool Chart is recommended
- ability to sense urge to defecate
- any straining to start and finish defecation
- symptoms of bloating or pain on, or between, bowel movements
- review functional ability, particularly the resident's ability to access and use the toilet (for example, can the resident get to the toilet, adjust their clothing, sit on the toilet at its normal height?)
- review the level of activity
- identify strategies the resident uses to encourage bowel movements (for example, laxatives, prunes, bran) and the effectiveness of these strategies
- establish dietary history (for example, preferred foods, fibre intake)
- identify dehydration, type of fluids preferred and usual daily intake
- establish cognitive status, particularly the resident's ability to communicate their needs and to follow simple instructions
- audit the environment for:
 - ease of access and signage to the toilets
 - level of privacy (for example, a shared bathroom).

Conduct a physical assessment of the abdomen and, where indicated, a digital rectal examination, including:

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

Interventions

The aim of intervention is to restore regular bowel actions (frequency, consistency and ease of passage of stools). 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 bowel cancer.
- Faecal impaction: seek medical advice.
- Treat underlying medical conditions that may be causing constipation.
- Constipation due to secondary causes: as per chronic constipation.

Chronic constipation

Promote regular bowel actions by developing and implementing an individualised bowel management plan, which may include:

- increasing fibre intake if the existing diet lacks adequate fibre (this should be introduced gradually to avoid adverse effects such as bloating or flatulence)
- foods that contain polyols (prunes, pears, stone fruit), soluble fibre (fruit, vegetables, wholegrain and wholemeal products, legumes, nuts and seeds) and insoluble fibre (wheat bran) [caution should be taken when introducing insoluble fibre and polyols to a resident with known irritable bowel syndrome (IBS), as these foods can exacerbate symptoms]
- increasing fluid intake, particularly if fibre intake has been increased (as the risk of faecal impaction occurring in immobile older people can increase)
 - laxative therapy – this option should be considered based on the type of constipation, comorbidities, lifestyle modifications used, tolerance and effectiveness
 - bulk-forming agents are indicated for mobile residents
 - osmotic aperients are indicated for bed-bound residents or when bulk-forming agents are not tolerated by mobile residents
 - non-bulk-forming laxatives are indicated for opioid-induced constipation
- medication review
- behaviour and lifestyle modifications (increased activity and exercise, environmental adaptations).

Once constipation has been resolved, implement prevention strategies.

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/day) if fluid restriction is not in place.
- Avoid caffeinated fluids.
- Gradually introduce and increase fibre intake to 21–25 g/day through dietary or supplemental sources as tolerated in mobile residents.
- Consider probiotic supplementation.

Behavioural

- Ensure dignity and privacy (visual and auditory) are safeguarded.
- Promote a regular toileting regimen based on the resident's usual pattern.
- Ensure correct positioning when seated on the toilet. Squat positioning (sitting on the toilet with the knees above the hips, with a foot stool to raise and support the feet if required; if bed-bound, lying on the left side with the knees bent towards the abdomen).
- Give the resident adequate time on the toilet.

Lifestyle

- Encourage and assist the resident to 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 full medical review including a medication review
- 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 bowel actions for frequency, character and 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)
- Ongoing monitoring of diet and fluid intake, exercise patterns and functional ability
- Monitor the resident's satisfaction with bowel patterns

Resident involvement

- Education and choices regarding dietary fibre, fluids and participation in exercise
- The role of toileting habits in maintaining bowel regularity
- Involvement in treatment options

Staff knowledge and education

- Physiology of constipation
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- Prevention of constipation
- Management options
- Physical examination of the abdomen.



Evidence base for this standardised care process

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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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Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Department of Health and Human Services, March 2018. (1802012)

ISBN 978-0-7311-6848-4(pdf)

Available from the department's website at <www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality/improving-resident-care/standardised-care-processes>.