Constipation in an Adult

Unique Identifier	CP01/BRD/133 – v03.00
Document Type	Clinical Guideline
Risk of non-compliance	may result in a small degree of harm to the patient/DHB
Function	Clinical Practice, Patient Care
User Group(s)	Auckland DHB only
• Organisation(s)	Auckland District Health Board
• Directorate(s)	All directorates
• Department(s)	All departments
• Used for which patients?	Adult patients with constipation
• Used by which staff?	All clinicians
• Excluded	Child Health
Keywords	Bowel, laxative
Author	Nurse Consultant – Adult Community and Long Term Conditions
Authorisation	
• Owner	Chief Nursing Officer
• Delegate / Issuer	Chief Nursing Officer
Edited by	Document Control
First issued	20 August 2014
This version issued	18 September 2020 - updated
Review frequency	3 yearly
Classification history	Reclassified from CP10/Adult/052

Contents

1. Purpose of guideline

The purpose of this guideline is to facilitate the safe and effective care of an adult patient with constipation within Auckland District Health Board (Auckland DHB).

This guideline excludes those patients with chronic constipation, spinal cord injury and those where there is no clear diagnosis.

2. Guideline management principles and goals

Bowel management should be based on current evidence based practice and assessment should be initiated within 24 hours.

3. Definitions

Constipation
A change in the individual's normal bowel habits, characterised by:

- A decrease in the frequency of bowel movements compared with their ambulatory baseline
- The absence of sensation of complete evacuation
- Reported need for increased straining with defecation.

Faecal impaction
Retention of hardened or putty-like stool in the rectum and colon, which cannot be passed by the patient as a result of incomplete evacuation over time. Often associated with watery, loose stools around the impacted mass.

- Faecal incontinence

An involuntary passage of stool at an inappropriate place or time. This may be related to cortical lesions, spinal cord lesions, injury to sphincter, perineal muscle relaxation, over use of laxatives, and functional status (e.g. cognitive impairment and impaired mobility).

4. Risk factors

4.1 Reduction in fluid intake

- Needing assistance to be able to drink
- Dislike of available fluids e.g. is on thickened fluids
- Is worried about urinary frequency and/or incontinence
- Lack of knowledge about importance of fluids
- Functional status e.g. cognitive or physical impairment.

4.2 Reduction in dietary fibre intake

- Poor dentition, decreased saliva production, or other chewing difficulties
- Available diet is low in fibre
- Decreased motivation to eat
- Poor memory

- Lack of knowledge about importance of dietary fibre or foods that contain it.

4.3 Reduction in physical activity

- Increasing frailty makes activity difficult, unsafe or impossible without assistance
- Sudden change in physical condition or health status
- Change in environment or usual routine
- Lack of knowledge about importance of regular physical activity.

4.4 Access to toilet facilities

- Need help getting to toilet and/or removing clothing
- Toilet seat wrong height, room too cold, lack of privacy, having to wait for others, having to use bedpan etc.

4.5 Medical condition

The following medical conditions can slow or obstruct the passage of stool through the gut, or makes it difficult or painful to pass stool:

- Neurological deficits e.g. stroke, multiple sclerosis, Parkinson's disease, brain/spinal cord injury
- Bowel obstruction e.g. adhesions, tumour
- Painful anal conditions e.g. haemorrhoids, fissures
- Irritable bowel disease
- Diverticulosis
- Megacolon, hypotonic bowel.

4.6 Medications

- Aluminium
- Antihistamines
- Antipsychotics (e.g. clozapine, phenothiazines)
- Tricyclic antidepressants
- Calcium antagonists e.g. diltiazem, verapamil
- Calcium supplements
- Cholestyramine
- Clonidine
- Diuretics
- Iron
- Levodopa
- Opioid analgesics (including codeine)
- Ondansetron.

5. Assessment

Patient assessment involves discussion about some or all of the following:

- Identifying risk factors
- Normal bowel pattern and history of constipation
- Medication review

- Abdominal assessment with rectal examination (if required)
- Use of a bowel chart and clear descriptions e.g. Bristol Stool Chart.

6. Management

6.1 Gastrocolic reflex

When a person smells, sees or eats food, gut mobility increases and moves food along the digestive tract. Usually within 30 minutes following stimulation, a person feels the need to defecate. Even if sensation is impaired due to paraplegia, defecation may still occur at this time. It can also be effective in the confused patient.

It is therefore important in bowel management to establish regular timed defecation. Once the urge to defecate is recognised, it should not be delayed, providing the place and time is appropriate. If the urge to defecate is deferred it may not return for 24 hours.

The longer faeces remains in the bowel, the dryer and harder it becomes and progressively more difficult to pass. It may take up to 4 weeks for regular timed defecation to become established.

6.2 Laxatives

Type of laxative	Use	Action and onset	Nursing points
Bulking agents e.g. Metamucil, Normacol, Psyllium	Suitable first time treatment for the mobile less frail older person Often used to treat diarrhoea secondary to nasogastric feeding.	Increase the volume of the stool by absorbing water. The increased volume stimulates peristalsis. Onset 12-24 hours	Dose should be taken with a large glass of water. Should not be given when nausea, vomiting undiagnosed abdominal pain or faecal impaction are present.
Osmotic laxative e.g. Lactulose	Lactulose is often the first choice of treatment in the frail and/or immobile elderly person	Lactulose syrup is poorly absorbed in the gastro-intestinal tract. It is broken down in the colon by bacteria to form acetic and lactic acids. These acids stimulate peristalsis and also exert a local osmotic effect, drawing water into the colon. Onset 24 - 72 hours	Lactulose can be mixed with water, milk or fruit juice to make it more palatable. Lactulose is more effective when used consistently. The patient on galactose and/or lactose-free diets may experience intestinal obstruction. Needs adequate fluid intake to work properly Can cause bloating.
e.g. Macrogols (Molaxole)		Onset 0.5 - 3hours	Macrogols are licensed for the treatment of faecal impaction.

Type of laxative	Use	Action and onset	Nursing points
			Macrogols appear to be at least as effective as lactulose and may cause less flatulence.
Faecal softeners e.g. Docusate sodium		Lowers surface tension and allows water to penetrate hard, dry faeces. Also has some stimulant activity Onset 6-12 hours	Often combined with stimulants (such as senna in Laxsol tablets). Stool softeners are unnecessary if stool is well hydrated and soft. Oral docusate should be avoided in a patient with intestinal obstruction.
Glycerine suppositories	Is a useful immediate option in the frail elderly person	Exert a local osmotic effect, drawing water into the rectum/lower colon. Increasing the pressure within the bowel which stimulates peristalsis, resulting in a bowel motion. Onset 5-30 minutes	Suppositories should be inserted pointed end first. Administer 1 - 2 suppositories as required and hold for at least 20 minutes. Should not be given if patient is experiencing nausea, vomiting, undiagnosed abdominal pain or faecal impaction.
Enemas Hyper osmolar e.g. Phosphate (fleet enemas) Microlax®		Retains water in the intestinal lumen by osmosis, which results in increased bulk and stimulates peristalsis. Onset 2-30 minutes Faecal softener, which liberates the water that is present. This causes a softening of the stool and leads to a gentle defecation	Contraindications – nausea, vomiting, abdominal pain and/or rectal bleeding Use with caution in a patient who has renal impairment and/or bowel stasis. Only use Fleet enemas on PRN basis.

Type of laxative	Use	Action and onset	Nursing points
		(also contains glycerol which stimulates peristalsis).	

7. Education for patients

Education to the patient and/or support person should include some or all of the following:

- A healthy bowel pattern
- The causes of constipation
- A well balanced diet, including adequate fibre and fluid
- Appropriate physical activity
- Optimising the gastro-colic reflex
- Use of natural laxatives or medications
- Providing the constipation hand-out prepared by Nutrition Services.

8. Monitoring

All practitioners should monitor and review patient's bowel status daily, and stop laxatives when appropriate.

All nursing staff should monitor, record, review patient's bowel status during every shift, and notify the medical practitioner overseeing the patient's care if loose stools are observed or the patient has still not moved their bowels.

9. Supporting evidence

- Allen-Dicker, J., Goldman, J. & Shah, B. (2015) Inpatient Constipation. *Hospital Medicines Clinics 4*(1) 51-64.
- Gallegos-Orozco, J., Foxx-Orenstein, A., Sterler, S. & Stoa, J. (2012) Chronic Constipation in the Elderly. *Am J Gastroenterol 107*, 18–25.
- Vasanwala, F. (2009) Management of Chronic Constipation in the Elderly. *The Singapore Family Physician 35*(3) 87-92.

10. Associated documents

- Bristol stool chart
- Constipation in Palliative Care - Adult
- Constipation in the Antenatal Patient

- Medications - Administration
- Medications - Allergies & Adverse Drug Reactions (ADRs) Identification, Documentation & Recording
- Medications - Prescribing

Clinical forms

- CR5504: Bowel Motion Chart
- CR5775: Bowel Chart Older People's Health

Patient information leaflets

The following leaflets can be printed from the Auckland DHB intranet / Nutritional Services / Nutrition information sheets.

- Constipation
- Fibre in your diet

11. Disclaimer

No guideline can cover all variations required for specific circumstances. It is the responsibility of the health care practitioners using this Auckland DHB guideline to adapt it for safe use within their own institution, recognise the need for specialist help, and call for it without delay, when an individual patient falls outside of the boundaries of this guideline.

12. Corrections and amendments

The next scheduled review of this document is as per the document classification table (page 1). However, if the reader notices any errors or believes that the document should be reviewed ***before*** the scheduled date, they should contact the owner or Document Control without delay.