

4 February 2022

Andrew McGregor

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Dear Andrew

### Official information request W21-695

I refer to your official information request received by the Ministry of Health on 25 November 2021, transferred to this DHB on 9 December 2021.

#### Request:

- 1: *"Please provide Guidelines/Procedures for the management of postoperative Urinary Retention (POUR)"*
- 2: *"Please provide Guidelines/procedure for the management/prevention of persistent Postsurgical Pain"*
- 3: *"Please provide Guidelines/procedure in the treatment of patients after a suicide attempt and/or suicidal ideation"*
- 4: *"Please provide Guidelines/procedure differentiating subtypes of primary (idiopathic) constipation"*

#### Response:

The information you have requested is below.

- 1: Please see attached "Urology Associates Protocols Procedure" Protocol 7
- 2: Please see attached "Patient Controlled Analgesia Guideline" & "Lippincott Procedures – Pain Management"
- 3: Mental Health, Addiction and Intellectual Disability Service (MHAIDS) are provided at Wairarapa DHB by Capital and Coast DHB, they will answer this question as part of their response to your request.
- 4: Please see attached "Lippincott Procedures – Constipation management, oncology"

You have the right, under section 28 of the OIA, to seek an investigation and review by the Ombudsman of this decision. Information about how to make a complaint is available at [www.ombudsman.parliament.nz](http://www.ombudsman.parliament.nz) or freephone 0800 802 602.

Please note that this response, or an edited version of this response, may be published on the Wairarapa District Health Board website no less than one week after the response has been provided to you. Any personal or identifying information will be redacted from any response published online. The DHB will endeavour to resolve any concerns you should raise but, subject to any legal grounds for withholding, ultimately reserves the right to publish any information.

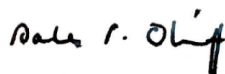
If you wish to discuss this response with us, please feel free to contact:

OIA Coordinator

Email: [OIArequest@wairarapa.dhb.org.nz](mailto:OIArequest@wairarapa.dhb.org.nz)

Ph: 06 946 9800

Yours sincerely



Dale Oliff

Chief Executive

## Urology Associates Protocols

<b>Type:</b> Procedure - Clinical	<b>HDSS Certification Standard:</b> [optional]
<b>Approval Level:</b> Clinical Board	<b>ELT Lead:</b> Director of Nursing
<b>Applicable To:</b> Clinical Staff	<b>Document Owner:</b> Clinical Lead, Urology Associates, Sharon English

### Purpose

The purpose of this document is to have a single point of reference for the protocols that Urology Associates utilize when treating patients referred from Wairarapa DHB

### Scope

All Wairarapa DHB staff involved in the referral of patients to Urology Associates

### Roles and Responsibilities

Wairarapa DHB staff involved in the referral of patients to Urology Associates and the treatment of patients by Urology Associates should familiarise themselves with the protocols.

### Procedure

Please refer to the Appendices for the individual Protocols

### Implementation and monitoring compliance with/effectiveness of document

The contents of these Protocols are provided by Urology Associates to be referred to by Wairarapa DHB staff. Any updates to these protocols will be provided by Urology Associates when amended.

<b>Document Author:</b> Clinical lead, Urology Associates, Sharon English		
<b>Approved By:</b> Clinical Board]		<b>Version:</b> [as per WrDHB Style Guide]
<b>Issue Date:</b> 17/09/2021	<b>Review Date:</b> 17/09/2024	<b>Date first issued:</b> 17/09/2021
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## Appendix 7 – Urinary Retention

# WAIRARAPA DHB UROLOGY PROTOCOL

## NUMBER : 7

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**PROTOCOL TITLE :** URINARY RETENTION

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### **INTRODUCTION:**

- Patients requiring catheterisation do not always require urological follow-up
  - Urinary retention associated with renal failure can lead to a post-obstructive diuresis, a potentially life-threatening scenario
- 

### **1. Initial diagnosis of urinary retention**

- 1.1 Confirm diagnosis (palpation of distended bladder or bladder scan)
- 1.2 Collect blood for U & Es

### **2. Management of urinary retention**

- 2.1 If retention has been preceded by gross haematuria, manage as per Urology Protocol Number 2: Haematuria Management
- 2.2 Place 16 G Fr urethral catheter
- 2.3 Allow bladder to empty and record volume drained
- 2.4 Send urine for microscopy, culture and sensitivities
- 2.5 If creatinine is less than 200, discharge (see below)
- 2.6 If creatinine is >200, observe patient for two hours:
  - 2.6.1 if urine output, after initial drainage, is > 200 mL per hour, commence treatment for post-obstructive diuresis – see 3 below
  - 2.6.2 if urine output, after initial drainage, is < 200 mL per hour, encourage oral fluid intake, discharge patient and arrange repeat creatinine in 2 to 3 days with GP

### **3. Management of post-obstructive diuresis**

- 3.1 Prescribe intravenous fluid replacement at a rate of 50% of urine output per hour
- 3.2 Urine needs hourly measurement and the iv fluid rate adjusted accordingly by nursing staff
- 3.3 Use one litre bags of normal saline
- 3.4 The patient will require admission to hospital overnight

### **4. Admission**


- 4.1 Patients in urinary retention can usually be discharged, unless they develop a post-obstructive diuresis.
- 4.2 Patient to be admitted under the on call General Surgeon.
- 4.3 If patient haemodynamically unstable, consider ICU involvement.

**5. Discharging a patient who is catheterised**

- 5.1 Supply patient with night bag and give catheter education
- 5.2 Prescribe doxazosin 4 mg daily for male patients if they are likely to tolerate this and are not currently on any therapy for benign prostatic hyperplasia
- 5.3 Complete District Nursing referral: a District Nurse should attend the next day
- 5.4 Refer to Urology service for outpatient review: a decision will be made and the patient contacted regarding a trial of void if that is thought appropriate.

SIGNED:

**Approval Authority Signature**

<b>Name:</b>	
<b>Role:</b>	Chair, Clinical Board
<b>Signature:</b>	Phil Halligan
<b>Date:</b>	17/9/21

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## New Zealand instance



### Pain management

#### ■ Introduction

Pain, considered the fifth vital sign, is defined by the International Association for the Study of Pain as the sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage. Thus, pain includes not only the perception of an uncomfortable stimulus, but also the response to that perception.

The patient's self-report of pain is the most reliable indicator of the existence of pain. When a patient feels severe pain, he seeks medical help because he believes the pain signals a serious problem. This perception produces anxiety, which, in turn, increases the pain. To assess and manage pain properly, the nurse must depend on the patient's subjective description in addition to objective tools, and any relevant pain history from which to make a comparison.

According to The Joint Commission, health care facilities are required to develop policies and procedures supporting the appropriate use of analgesics and other pain control therapies. Pain should be assessed at admission and be reassessed at regular intervals. Pain assessment should include personal, cultural, spiritual, and ethnic beliefs. Patients and families should be educated about their role in pain management. They should also be informed about potential limitations and adverse effects of pain treatment.

Several interventions can be used to manage pain, including analgesics, emotional support, comfort measures, and complementary and alternative therapies such as cognitive techniques to distract the patient. The Analgesic Ladder provides a useful stepped approach to the use of analgesics and adjuvants. Mild pain can be treated with non-opioids such as aspirin or paracetamol, while more severe pain responds to strong opioids such as morphine. Acute severe pain is best treated using the intravenous route in order to effectively titrate pain relief.

Invasive measures, such as epidural analgesia or patient-controlled analgesia (PCA), may also be required.

#### ■ Equipment

- Pain assessment tool or scale

#### ■ Implementation

- Perform hand hygiene.
- Assess the patient's pain by using a pain assessment tool or scale or by asking key questions and noting his response to the pain. For instance, ask him to describe its duration, severity, and location. Look for physiologic or behavioral clues to the pain's severity.(See below How to assess pain.)
- Establish with the patient what a low pain level means. Generally, this number is no more than 4 on the 0-10 scale.
- Work with the patient to develop a nursing care plan using interventions appropriate to the patient's lifestyle. These may include prescribed medications, emotional support, comfort measures, complementary and alternative therapies such as cognitive techniques, and education about pain and its management. Emphasize the importance of maintaining good bowel habits, respiratory functions, and mobility because pain may exacerbate any problems in these areas.
- Explain to the patient how pain medications work together with other pain management therapies to provide relief. Also explain that management aims to keep pain at a low level to permit optimal bodily function.
- Implement your care plan. Because individuals respond to pain differently, you'll find that what works for one person may not work for another.

#### HOW TO ASSESS PAIN

To assess pain effectively, you'll need to consider the patient's ability to understand and communicate, depending on age, cognitive ability and preferred language. As part of the pain assessment you will need to consider the patient's description of the pain as well as observations of behavioural responses and physical functioning. Start by asking this series of key questions (bearing in mind that the patient's responses will be shaped by his prior experiences, self-image, and beliefs about his condition):

- **O**nset and duration. "When did the pain start?"
- **P**rovokes or relieves. "What makes the pain worse, or better?"
- **Q**uality or character. "Describe the pain."

- **Region(s)/Radiate.** "Where is the pain?"
- **Severity/intensity.** "How sore are you at rest? On movement?"
- **Timing.** "Is the pain constant, or intermittent?" Is the pain associated with other symptoms such as nausea, vomiting, diarrhoea?
- **Understand response.** "What do you think or feel about this pain?" "What are your expectations for treating this pain?"

Ask the patient to rank the severity and intensity of his pain, using an age cognitively appropriate and language sensitive tool or scale of 0 to 10 (Numerical Pain Scale), with 0 denoting no pain and 10 denoting the worst pain level ever. This rating helps the patient verbally evaluate pain therapies. It is important to assess pain both when the patient is resting and when he is active.

Features in the pain history might suggest the presence of neuropathic pain. Please link to WDHB's IPS Handbook p. 100-102 for more on this.

Assess the pain regularly throughout the day, especially before and after giving analgesia, and through the night (when pain is usually heightened). Keep in mind that the ability to sleep doesn't indicate absence of pain.

Observe the patient's behavioral and physiologic responses to pain. Physiologic responses may be sympathetic or parasympathetic, but remember the absence of physiologic responses doesn't mean an absence of pain.

### **Behavioral responses**

These include altered body position, moaning, sighing, grimacing, withdrawal, crying, restlessness, muscle twitching, and immobility.

Scales such as PAINAD (The Pain Assessment Checklist for Seniors with Limited Ability to Communicate) and, CNPI (Checklist of Nonverbal Pain Indicators) are behavioural tools for use in the assessment of pain in older adults with communication difficulties secondary to cognitive impairment/dementia. Link to WDHB IPS Handbook Appendix VI.

### **Sympathetic responses**

These are commonly associated with mild to moderate pain and include pallor, elevated blood pressure, dilated pupils, skeletal muscle tension, dyspnea, tachycardia, and diaphoresis.

### **Parasympathetic responses**

These are commonly associated with severe, deep pain and include pallor, decreased blood pressure, bradycardia, nausea and vomiting, weakness, dizziness, and loss of consciousness.

## **Giving medications**

- Before administering and pain relief, confirm the patient's identity using at least two patient identifiers according to your facility's policy.
- If the patient is allowed oral intake, begin with a nonopioid analgesic, such as paracetamol, every 4 to 6 hours as ordered.
- If the patient needs more relief than a nonopioid analgesic provides, you may want to consider giving a mild opioid such as codeine or tramadol as ordered, or a strong opioid such as morphine as prescribed. Administer oral medications if possible. Check the appropriate drug information for each medication given. There are many other adjuvant drugs which may improve pain management and could be worth considering e.g. amitriptylline for neuropathic pain.
- If ordered, teach the patient how to use a Patient-controlled analgesia (PCA) device. Such a device can help the patient manage his pain and decrease his anxiety. (See the "[Patient-controlled analgesia](#)" procedure.)
- Assess pain according to your facility's guidelines after parenteral medication administration. Following oral medication administration assess pain within 60 minutes. If the patient is still in pain, reassess him and alter your care plan as appropriate, and consider asking for medical assistance.

## **Providing emotional support**

- Pain can cause or exacerbate anxiety. Show your concern by spending time talking with the patient. Discuss the patient's concerns if he is frustrated or anxious about his pain and provide clear information about pain management.

## **Performing comfort measures**

- Reposition the patient periodically to reduce muscle spasms and tension and to relieve pressure on bony prominences. Increasing the angle of the bed can reduce pull on an abdominal incision, diminishing pain. If appropriate, elevate a limb to reduce swelling, inflammation, and pain.
- Splinting or supporting abdominal and chest incisions with a pillow when coughing or changing position helps decrease pain.
- Apply cold compresses, as appropriate, to decrease discomfort.
- Give the patient a back massage to help reduce tense muscles.



- Perform passive range-of-motion exercises to prevent stiffness and further loss of mobility, relax tense muscles, and provide comfort.
- Provide oral hygiene. Keep a fresh water glass or cup at the bedside because many pain medications tend to dry the mouth.
- Wash the patient's face and hands to soothe the patient, which may reduce his perception of pain.

### Using complementary and alternative therapies such as cognitive therapy

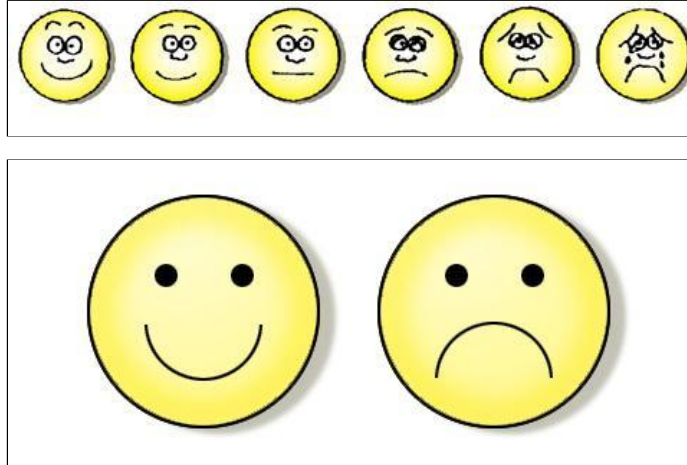
- Help the patient enhance the effect of analgesics by using such techniques as distraction, guided imagery, deep breathing, and relaxation. You can easily use these "mind-over-pain" techniques at the bedside. Choose the method the patient prefers. If possible, start these techniques when the patient feels little or no pain. If he feels persistent pain, begin with short, simple exercises. Before beginning, dim the lights, remove the patient's restrictive clothing, and eliminate noise from the environment.
- For distraction, have the patient recall a pleasant experience or focus his attention on an enjoyable activity. For instance, have him use music as a distraction by turning on the radio when the pain begins. Have him close his eyes and concentrate on listening, raising or lowering the volume as his pain increases or subsides. Note, however, that distraction is usually helpful in relieving pain lasting for brief episodes or for painful procedures of short duration.
- For imagery, help the patient concentrate on a peaceful, pleasant image, such as walking on the beach. Encourage him to concentrate on the details of the image he has selected by asking about its sight, sound, smell, taste, and touch. The positive emotions evoked by this exercise minimize pain.
- For deep breathing, have the patient stare at an object, then slowly inhale and exhale as he counts aloud to maintain a comfortable rate and rhythm. Have him concentrate on the rise and fall of his abdomen. Encourage him to feel more and more weightless with each breath while he concentrates on the rhythm of his breathing or on any restful image.
- For muscle relaxation, have the patient focus on a particular muscle group. Then ask him to tense the muscles and note the sensation. After 5 to 7 seconds, tell him to relax the muscles and concentrate on the relaxed state. Have him note the difference between the tense and relaxed states. After he tenses and relaxes one muscle group, have him proceed to another and another until he's covered his entire body.

### ■ Special Considerations

- During periods of intense pain, the patient's ability to concentrate diminishes. If your patient is in severe pain, help him to select a cognitive technique that's easy to use. After he selects a technique, encourage him to use it consistently. Remind the patient that results of cognitive therapy techniques improve with practice. Help him through the initial sessions.
- Pain shouldn't be considered a normal part of the aging process. Provide pain relief for the elderly patient using pharmacologic and nonpharmacologic approaches. Remember, safety is a special concern, especially the risk for falls due to impaired mobility from pain and from adverse effects from pain medications.
- It's important to identify age-related factors that affect assessment and pain management in elderly patients. For instance does the elderly patient have cognitive impairment?
- Remember too that elderly patients may have a number of medical conditions for which they are being treated. The addition of pain medications may increase the risk of adverse effects due to drug interactions.
- Evaluate your patient's response to pain management. If he's still in pain, reassess him and alter your care plan as appropriate.
- Culture and beliefs affect behavioral responses to pain and treatment preferences. Therefore, you must take into account the patient's expectations regarding pain relief when developing the care plan.
- Patients receiving opioid analgesics may be at risk for developing tolerance, dependence, or addiction. However, studies have demonstrated that addiction during acute pain treatment is less than one percent.
- Addiction is defined as psychological dependence characterized by a persistent pattern of dysfunctional drug use. The patient's behavior will be characterized by a craving for the drug to experience effects other than pain relief. A patient demonstrating such behavior usually has a pre-existing problem that's exacerbated by the opioid use. Discuss the addicted patient's problem with supportive personnel, and make appropriate referrals to experts.
- Physical dependence is a physiologic state in which withdrawal symptoms occur with abrupt cessation or reversal of the drug. Physical dependence doesn't mean that addiction coexists. Symptoms include anxiety, irritability, chills and hot flashes, excessive salivation and tearing, rhinorrhea, sweating, nausea, vomiting, and seizures. These signs and symptoms are likely to begin within 6 to 12 hours and peak within 24 to 72 hours of discontinuing the drug. To reduce the risk of dependence, discontinue an opioid by decreasing the dose gradually each day. You may also switch to an oral opioid and decrease its dose gradually.
- Tolerance is a neuro-adaptive response that results in a decrease to one or more of the effects of the drug over time, such as decreased analgesia or sedation. Tolerance doesn't mean that addiction coexists.
- If your patient has dementia or some other cognitive impairment, don't assume that he can't understand the pain scale or communicate about his pain. Experiment with several pain scales. A scale featuring faces, such as the Wong-Baker FACES scale or the Faces Pain Scale - are both good choices for many cognitively impaired patients and those with limited language skills. (See [Visual pain rating scale.](#))

### VISUAL PAIN RATING SCALE

You can evaluate pain in a nonverbal manner for pediatric patients age 3 and older and for adults with language difficulties. One instrument is the Wong-Baker FACES pain rating scale; another, two simple faces such as the ones shown below. Ask the patient to choose the face that describes how he's feeling — either happy because he has no pain, or sad because he has some or a lot of pain. Alternatively, to pinpoint varying levels of pain, you can ask the patient to draw a face.



Hockenberry, M.J., et al. Wong's Essentials of Pediatric Nursing, 7th ed. St. Louis: Mosby, Inc., 2005. Reprinted with permission.

### ■ Complications

The most common adverse effects of opioid analgesics include sedation, constipation, nausea, vomiting and itch. Respiratory depression, the most serious happens less commonly though is much feared.

### ■ Documentation

Document each step of the nursing process. Describe the subjective information you elicited from the patient, using his own words. Note the location, quality, and duration of the pain as well any precipitating factors.

Record your nursing diagnoses; include the pain-relief method selected and the patient's rating of the pain before and after pain management interventions. Use a flow sheet to document pain assessment findings. Summarize your actions including the name and dosage of any medication given, and the patient's response. If the patient's pain wasn't relieved, note alternative treatments to consider the next time pain occurs. Also record any complications of drug therapy.

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## New Zealand instance



# Constipation management, oncology

Revised: November 19, 2021

## ■ Introduction

Constipation is the decreased passage of stool characterized by infrequent bowel movements, hard stool, the sensation of abdominal bloating or cramping, straining with bowel movements, and the feeling of incomplete evacuation.<sup>[1]</sup> It may be a symptom of cancer, an adverse effect of treatment, or the result of tumor progression.<sup>[2]</sup> Constipation may be accompanied by abdominal discomfort, abdominal distention, anorexia, and headache.<sup>[3]</sup>

Factors that increase a patient's risk of constipation include mechanical pressure on the bowel (caused by ascites, a tumor, or an obstruction), spinal cord damage, decreased mobility, dehydration, inadequate dietary fiber intake, metabolic and endocrine disorders, use of certain medications, and laxative overuse. Constipation affects one-half of patients with advanced cancer and most patients being treated with opioids.<sup>[1][4]</sup>

Managing constipation in patients with cancer is challenging and complex because it commonly has more than one cause. Patients also may be embarrassed to discuss the problem, so it may go unrecognized until a patient is in distress. Prevention and early intervention are the keys to avoiding such complications as nausea, vomiting, malaise, hemorrhoids, anal fissures, abdominal and rectal pain, paralytic ileus, and bowel obstruction and perforation, which can occur if constipation progresses. Teaching patients about measures to prevent constipation and encouraging them to report symptoms when they occur is essential. Various pharmacologic and nonpharmacologic interventions are available for treating constipation. Treatment should be individualized according to the patient's history, treatment regimen, and condition.<sup>[1]</sup>

## ■ Equipment

- Prescribed medications
- Vital signs monitoring equipment
- Stethoscope
- Disinfectant pad
- Severity of constipation grading tool
- Optional: bedside commode, assistive devices, gloves, gown, mask with face shield or mask and goggles, enema administration equipment

## ■ Preparation of Equipment

Inspect all equipment and supplies. If a product is expired, is defective, or has compromised integrity, remove it from patient use, label it as expired or defective, and report the expiration or defect as directed by your facility.

## ■ Implementation

- Review the patient's medical record for cancer diagnosis, grading, and staging; treatment regimen; history of surgical procedures; and other conditions that can increase the risk of constipation.<sup>1</sup>
- Gather and prepare the necessary equipment and supplies.
- Perform hand hygiene.<sup>5 6 7 8 9 10</sup>
- Put on gloves, a gown, a mask with a face shield or a mask and goggles, as needed, to comply with standard precautions.<sup>11 12 13</sup>
- Confirm the patient's identity using at least two patient identifiers.<sup>14</sup>
- Provide privacy.<sup>15 16 17 18</sup>
- Obtain the patient's vital signs.
- Obtain a dietary history from the patient to assess fluid and fiber intake.<sup>1</sup>
- Assess the patient's GI status, including the characteristics of bowel sounds, if present. Assess for abdominal distention, pain, and cramping.<sup>1</sup>

- Ask the patient about elimination patterns, including the date of the last bowel movement, the frequency and character of stools (amount, color, consistency, and presence of blood), and the use of laxatives, stool softeners, and other measures to enhance bowel function.<sup>[1]</sup>
  - For suspected ileus or mechanical obstruction, arrange for an abdominal X-ray as ordered.<sup>[1][4]</sup>
  - Assist with maintaining the patient's usual bowel habits during hospitalization.<sup>[1]</sup>
  - When the patient has the urge to defecate, provide a private, quiet, comfortable environment. Assist the patient to the toilet or commode and provide assistive devices, if needed, because assuming an upright position facilitates bowel evacuation.<sup>[19]</sup> Avoid using a bedpan whenever possible.
  - If the patient has the urge to defecate but can't pass stool, perform a digital rectal examination (unless contraindicated) to check for a low fecal impaction. If the patient's condition allows, perform manual disimpaction after administering an analgesic, a sedative, or both, as prescribed, following safe medication practices.<sup>[20][21][22][23]</sup> The practitioner may also order an oil retention enema to soften hard stool. (See the "[Fecal impaction removal, digital](#)" and "[Enema administration](#)" procedures.)<sup>[4]</sup>
- ◆ **Clinical alert:** Don't perform digital rectal examination, perform stoma manipulation, or administer suppositories or enemas to a patient with myelosuppression because doing so can increase the risk of infection and bleeding.<sup>[1]</sup> ◆
- If the patient reports nausea, vomiting, anorexia, cramping, or abdominal distention and passes liquid stool, suspect an impaction high in the ascending or transverse colon.<sup>[1][4]</sup> Administer an oral laxative and an enema (unless contraindicated), as needed and prescribed, following safe medication practices<sup>[20][21][22][23]</sup> to relieve the impaction.<sup>[4]</sup>
  - Monitor laboratory test results to detect possible causes of constipation, such as hypercalcemia, hypokalemia, hypothyroidism, and diabetes mellitus. Treat the cause as prescribed.<sup>[4]</sup> Notify the practitioner of critical test results within your facility's established time frame so that the patient can be treated promptly.<sup>[24]</sup>
  - Encourage adequate fluid intake (3,000 mL of fluid per day, unless medically contraindicated).<sup>[1]</sup> Note that warm or hot liquids may help stimulate bowel movement. Discourage the patient from drinking coffee, tea, and grapefruit juice because they have a diuretic effect.
  - For a patient who has adequate fluid intake, isn't in the late stages of cancer, and doesn't have structural bowel obstruction, encourage increasing the amount of fiber in the diet because fiber facilitates the passage of feces through the intestines and reduces the risk of fecal impaction.<sup>[1]</sup> Advise the patient to slowly increase fiber intake by adding 3 to 4 g/day and then increasing to 6 to 10 g/day to prevent fiber intolerance. High-fiber foods include bran, beans, seeds, nuts, vegetables, fruits, and whole grains.<sup>[1]</sup>

- Use mealtimes to establish a bowel routine to take advantage of the gastrocolic reflex that naturally occurs 5 to 15 minutes after eating.<sup>19</sup>
- Record the patient's bowel movements and initiate an individualized bowel management regimen if the patient doesn't have a bowel movement for 3 days.
- Administer medications, as prescribed, following safe medication administration practices.<sup>20 21 22 23</sup> (See [Medications used to manage constipation.](#))

<b>MEDICATIONS USED TO MANAGE CONSTIPATION</b>		
Various medications can be used to manage constipation in patients with cancer. The particular agent should be chosen based on the patient's history, condition, and therapeutic regimen.		
<b>Medication</b>	<b>Mechanism of action</b>	<b>Special considerations</b>
Bulk-forming laxatives (psyllium)	Cause water retention in the stool	<ul style="list-style-type: none"> <li>• Must be taken with 200 to 300 mL of water</li> <li>• May cause flatulence, abdominal distention, bloating, mechanical obstruction, and anaphylactic reactions</li> <li>• Should be used cautiously in patients with severe constipation and advanced cancer</li> </ul>
Emollient suppositories (glycerin) <sup>4</sup>	Coat and soften stool	<ul style="list-style-type: none"> <li>• Can lead to perianal irritation in excessive doses</li> <li>• May be effective in relieving fecal impaction</li> </ul>

Iso-osmotic laxatives (polyethylene glycol)	Block water absorption from stool in the large intestine, thus making stools softer	<ul style="list-style-type: none"> <li>• Are available with or without electrolytes (solution form)</li> <li>• Are used to treat persistent constipation</li> </ul>
Osmotic laxatives (sorbitol, lactulose) <sup>4</sup>	Soften stool by attracting and retaining water in the bowel	<ul style="list-style-type: none"> <li>• Usually take effect in 24 to 72 hours</li> <li>• May cause abdominal pain or cramping, flatulence, and abdominal distention</li> </ul>
Peripherally acting opioid agonists (methylnaltrexone) <sup>4</sup>	Prevent opioids from binding to the mu-receptors of the GI tract, thereby relieving opioid-induced constipation while maintaining pain control	<ul style="list-style-type: none"> <li>• Are used for opioid-induced constipation in patients with advanced cancer who are receiving palliative care</li> <li>• Shouldn't be used in patients with postoperative ileus or a mechanical bowel obstruction</li> <li>• May cause flatulence, abdominal pain, and nausea</li> </ul>
Prokinetic agents (metoclopramide) <sup>4</sup>	Stimulate peristalsis	<ul style="list-style-type: none"> <li>• Are used to combat delayed gastric emptying</li> <li>• Usually are taken before meals and at bedtime</li> <li>• Shouldn't be used in patients with large abdominal tumors or bowel</li> </ul>



		obstruction
Saline laxatives (saline mixture containing magnesium salts or sulfate ions)	Draw fluid into the gut by osmosis, which in turn softens stool and stimulates peristalsis	<ul style="list-style-type: none"> <li>• Can cause dehydration with repeated use</li> <li>• Shouldn't be used in patients who can't tolerate fluid loss or can't maintain adequate daily fluid intake</li> </ul>
Stimulant laxatives (bisacodyl, senna) <sup>4</sup>	Stimulate motility in the colon	<ul style="list-style-type: none"> <li>• Are used most commonly as part of a prophylactic bowel regimen</li> <li>• May be given two or three times per day to achieve an unforced bowel movement every 1 to 2 days</li> <li>• May cause abdominal discomfort, electrolyte imbalances, hepatotoxicity, and allergic reactions</li> </ul>

- Encourage the patient to exercise regularly, as tolerated, to promote GI motility.<sup>1 4</sup> If the patient can't exercise, encourage an increase in physical activity, as tolerated, or provide passive exercise to promote the urge to defecate.<sup>1</sup>
- Consult a practitioner specially trained in aromatherapy (if available at your facility) because abdominal massage using essential oils, such as rosemary, peppermint, and lemon, may help relieve constipation.<sup>25</sup>
- If the patient receives opioids to manage pain, collaborate with the health care team about using alternative medications to decrease constipation. For example, use an opioid agonist-opioid antagonist combination drug (such as oxycodone and naloxone) to relieve pain with fewer constipating effects.<sup>1 2</sup>

- Teach the patient abdominal exercises and diaphragmatic breathing to increase muscle tone and subsequently aid defecation.
- Remove and discard your personal protective equipment, if worn. [13](#)
- Perform hand hygiene. [5](#) [6](#) [7](#) [8](#) [9](#) [10](#)
- Clean and disinfect your stethoscope using a disinfectant pad. [26](#) [27](#)
- Perform hand hygiene. [5](#) [6](#) [7](#) [8](#) [9](#) [10](#)
- Grade the severity of the patient's constipation using a facility-approved tool. (See [Grading constipation severity.](#))

<< SCROLL >>

## GRADING CONSTIPATION SEVERITY

A grading system commonly helps describe the severity of adverse events related to cancer therapy. To grade the severity of a patient's constipation, you can use the Common Terminology Criteria for Adverse Events, developed by the National Cancer Institute. [28](#) The tool provides consistent terms for adverse events that result from therapy and consists of five grades:

- Grade 1 — Occasional or intermittent symptoms require occasional use of stool softeners, laxatives, dietary modifications, or enemas.
- Grade 2 — Persistent symptoms require regular use of enemas or laxatives and limit instrumental activities of daily living (ADLs).
- Grade 3 — Obstipation requires manual evacuation and limits self-care ADLs.
- Grade 4 — Life-threatening complications require urgent intervention.
- Grade 5 — Death results from the adverse event.

From U.S. Department of Health and Human Services, National Institutes of Health, & National Cancer Institute. (2017). Common terminology criteria for adverse events (CTCAE): Version 5.0. Retrieved October 2021 from [https://ctep.cancer.gov/protocolDevelopment/electronic\\_applications/docs/CTCAE\\_v5\\_Quick\\_Reference\\_8.5x11.pdf](https://ctep.cancer.gov/protocolDevelopment/electronic_applications/docs/CTCAE_v5_Quick_Reference_8.5x11.pdf)

- Document the procedure. [29](#) [30](#) [31](#) [32](#)

## ■ Special Considerations

- Because vinca alkaloids decrease GI motility, patients receiving these agents should use a combination laxative-stool softener to prevent constipation.<sup>1</sup>

## ■ Patient Teaching

Teach the patient and family (if applicable) about measures to prevent constipation, such as increasing physical activity (as tolerated), drinking 3,000 mL of fluid per day (unless medically contraindicated), and increasing fiber intake.<sup>1</sup> Instruct the patient about the importance of developing a routine bowel regimen. Advise the patient to report constipation. Teach about the complications that can occur if constipation is allowed to persist. Stress the importance of notifying the practitioner if 3 days pass without a bowel movement.<sup>1</sup>

## ■ Complications

Failure to manage constipation adequately may cause such complications as rectal bleeding, fluid and electrolyte imbalances, fecal impaction, bowel obstruction or perforation, and sepsis.<sup>1</sup>

## ■ Documentation

Document your assessment findings; the patient's intake and output, including the characteristics of any bowel movements; and the constipation severity grade. Record your interventions and the patient's response to those interventions. Document teaching provided to the patient and family (if applicable), their understanding of that teaching, and any need for follow-up teaching.

## ■ Related Procedures

- [Confusion management, long-term care](#)
- [Diarrhea management, oncology](#)
- [Hypercalcemia emergency patient care, oncology](#)
- [Syndrome of inappropriate antidiuretic hormone secretion, emergency patient care, oncology](#)

## ■ References

([Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions](#))

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### **Rating System for the Hierarchy of Evidence for Intervention/Treatment Questions**

The following leveling system is from *Evidence-Based Practice in Nursing and Healthcare: A Guide to Best Practice* (2<sup>nd</sup> ed.) by Bernadette Mazurek Melnyk and Ellen Fineout-Overholt.

Level I: Evidence from a systematic review or meta-analysis of all relevant randomized controlled trials (RCTs)

Level II: Evidence obtained from well-designed RCTs

Level III: Evidence obtained from well-designed controlled trials without randomization

Level IV: Evidence from well-designed case-control and cohort studies

Level V: Evidence from systematic reviews of descriptive and qualitative studies

Level VI: Evidence from single descriptive or qualitative studies

Level VII: Evidence from the opinion of authorities and/or reports of expert committees

Modified from Guyatt, G. & Rennie, D. (2002). *Users' Guides to the Medical Literature*. Chicago, IL: American Medical Association; Harris, R.P., Hefland, M., Woolf, S.H., Lohr, K.N., Mulrow, C.D., Teutsch, S.M., et al. (2001). Current Methods of the U.S. Preventive Services Task Force: A Review of the Process. *American Journal of Preventive Medicine*, 20, 21-35.

