CONSTIPATION

Constipation is the irregular, infrequent or difficult evacuation of the bowels[1].

Possible causes include:

- General debility, low food and fluid intake
- Drug therapy, e.g opioids, codeine, iron, anti-parkinsonian drugs.
- Spinal cord compression
- Hypercalcaemia
- Bowel obstruction
- Depression, fear of diarrhoea, incontinence.

Symptoms include:

- Anorexia
- Vomiting/ nausea
- Abdominal discomfort or cramping
- Diarrhoea/ overflow
- Confusion
- Anxiety
- Bowel obstruction
- Pain

Management of Constipation:

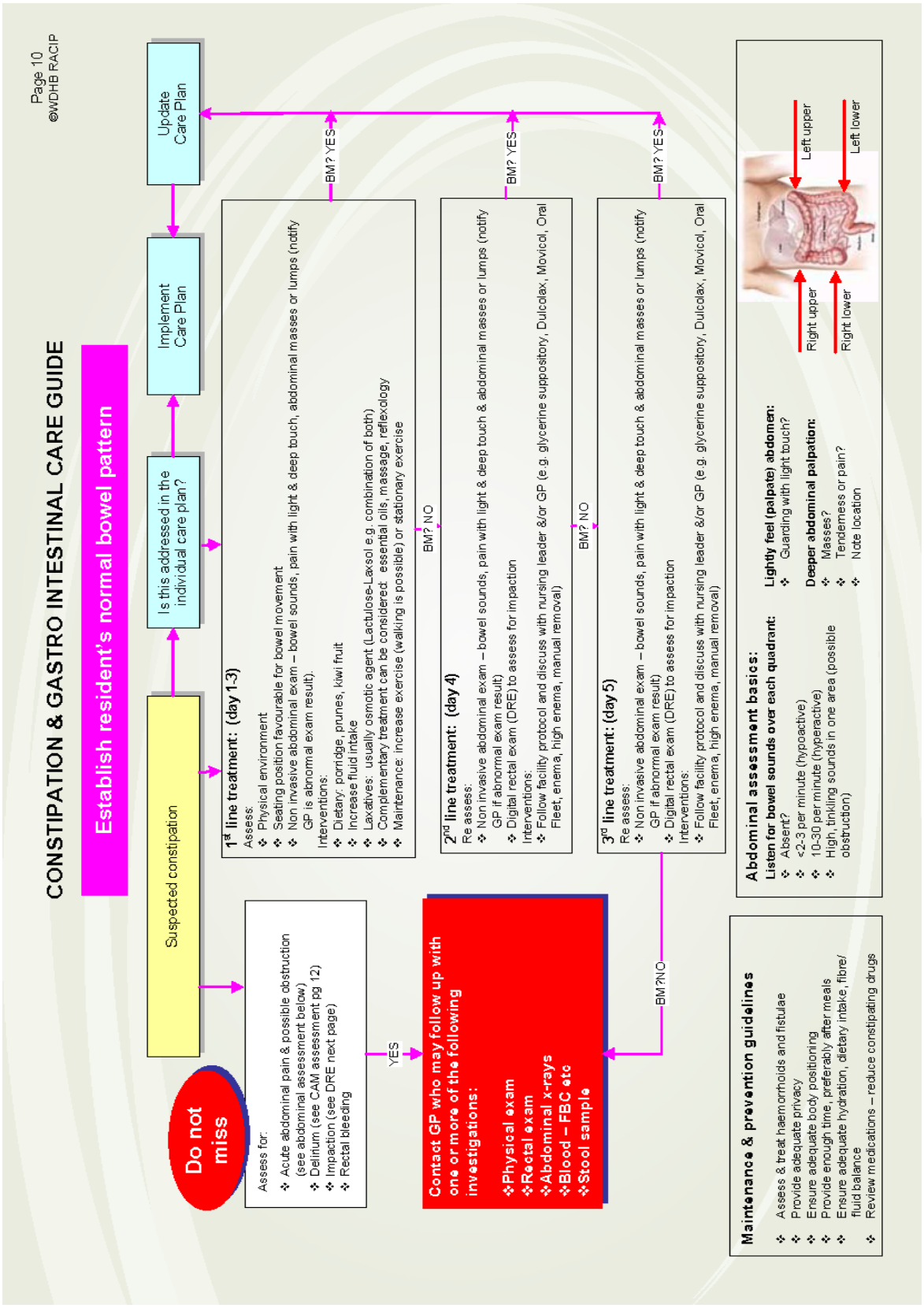
- The following two pages (Constipation and Gastro intestinal Care Guide) from Waitemata District Health Board[2] (2012) is a useful resource for assessment and treatment of constipation. Copies are available online, or through nznogerontology@gmail.com
- For residents who have a specialist palliative care need (Hospice), then management may differ slightly, and therefore it is important to keep regular contact with your Palliative Care Co-ordinator.
- When opioids are prescribed anticipate constipation. Attached is the algorithm for the management of constipation for residents taking opioids. If bowel obstruction is suspected it is imperative to seek specialist palliative care advice.
- All patients on opioids (except those with malabsorption or an ilesotomy) require regular aperients.
- Use of the Bristol Stool Chart is recommended for identifying bowel motion types, and constipation
- Do not perform a PR or insert suppositories in patients who are neutropenic without consultation with the GP, or specialist palliative care service
- Faeces consist of approximately 50% water, 25% bacteria, and 25% food residue so even if the resident is not eating there will be faeces in the bowel[1].

[1] Macleod, R., Vella-Brincat, J., & MacLeod, S. (2016). The Palliative Care Handbook. Retrieved from http://www.hospice.org.nz/cms_show_download.php?id=1243

[2] Waitemata District Health Board (2012). RN Care Guides for Residential Aged Care. Retrieved https://www.healthpoint.co.nz/public/older-peoples-health/waitemata-dhb-residential-aged-care-integration/

CONSTIPATION

CONSTIPATION IN THE OLDER PERSON[2]



DRUGS OVERVIEW

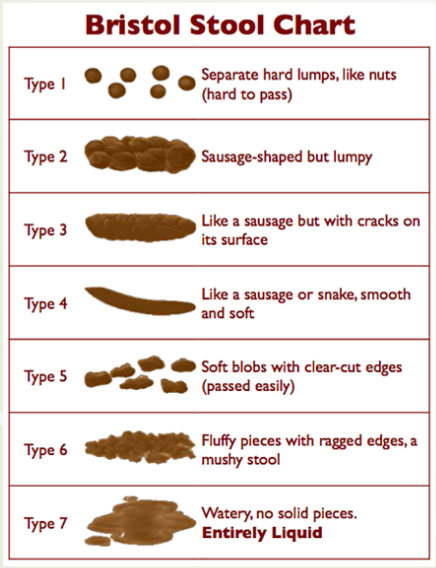
Types of drugs used for constipation:

1. **Bulking agents (ie psyllium (Metamucil), calcium polycarbophil (Fibercon)** - good for maintenance.
   - Must have adequate fluid intake at the time of administration (1 full glass of water).
   - These agents require 2-3 days to exert their effect and are not suitable for acute relief.
   - Avoid if peristalsis is impaired, such as for late stage Parkinson's Disease, Stroke or Spinal Injury and existing faecal impaction or bowel obstruction.
2. **Osmotic Agents (lactulose, Movicol)** - maintain fluid content in the stool.
   - Often the first choice for constipation because they are gentle with few side effects.
3. **Stool Softeners (docusate)** - alter the the surface tension of the faecal mass.
   - Good for those with hard stools, excessive straining, anal fissures or haemorrhoids.
   - Psyllium has been shown to be more effective than stool softeners for chronic constipation.
   - Not a good choice for impaired peristalsis.
4. **Stimulants (senna, bisacodyl, docusate sodium)** - stimulate intestinal movement.
   - Use sparingly, it can result in electrolyte imbalance and abdominal pain.
   - Prolonged use can precipitate lack of colon muscle tone and hypokalaemia.
   - Contraindicated in suspected intestinal blockages.

Suppositories: Medicated suppositories should be inserted blunt end first, Lubricant suppositories should be inserted pointed end first.

a. **Lubricant (glycerine)** - lubricate anorectum and have a stimulant effect. Should be inserted into the faecal mass to aid softening of the mass. No significant side effects.
b. **Stimulant (glycerol, bisacodyl)** - must be inserted against the mucous membrane of the rectum, and not into the faecal mass
c. **Osmotic (rectal phosphates)**
e. **Stool Softening (docusate sodium).** Side effects can include electrolyte imbalance and abdominal pain.

Bristol Stool Chart



Diarrhoea – assess for the following:

- Self limiting, sudden onset diarrhoea
- Food poisoning
- Overflow related to constipation (see DRE guidelines below)
- Pre-existing medical condition causing diarrhoea
- Overuse of laxatives
- C. difficile (potentially serious)

Treatment: Monitor and rehydrate.
If symptoms persist (>3 days duration) request GP assessment

Digital Rectal Examination (DRE)

- Obtain consent
- Observe area for haemorrhoids/rectal prolapse/tears
- Lying (L) lateral with knees flexed if able
- Gloved index finger well lubricated
- Gently using one finger only

Manual Removal

- Should be avoided if possible & only used if all other methods have failed (or if part of the individual care plan)
- Obtain consent
- Lying in (L) lateral position
- Observe for haemorrhoids/rectal prolapse/tears
- Take pulse as a baseline
- Use well lubricated gloved finger
- Gently using one finger
- Remove small amounts at a time
- Stop if distressed or pulse rate drops

ENEMAS & SUPPOSITORIES

Administration of enema

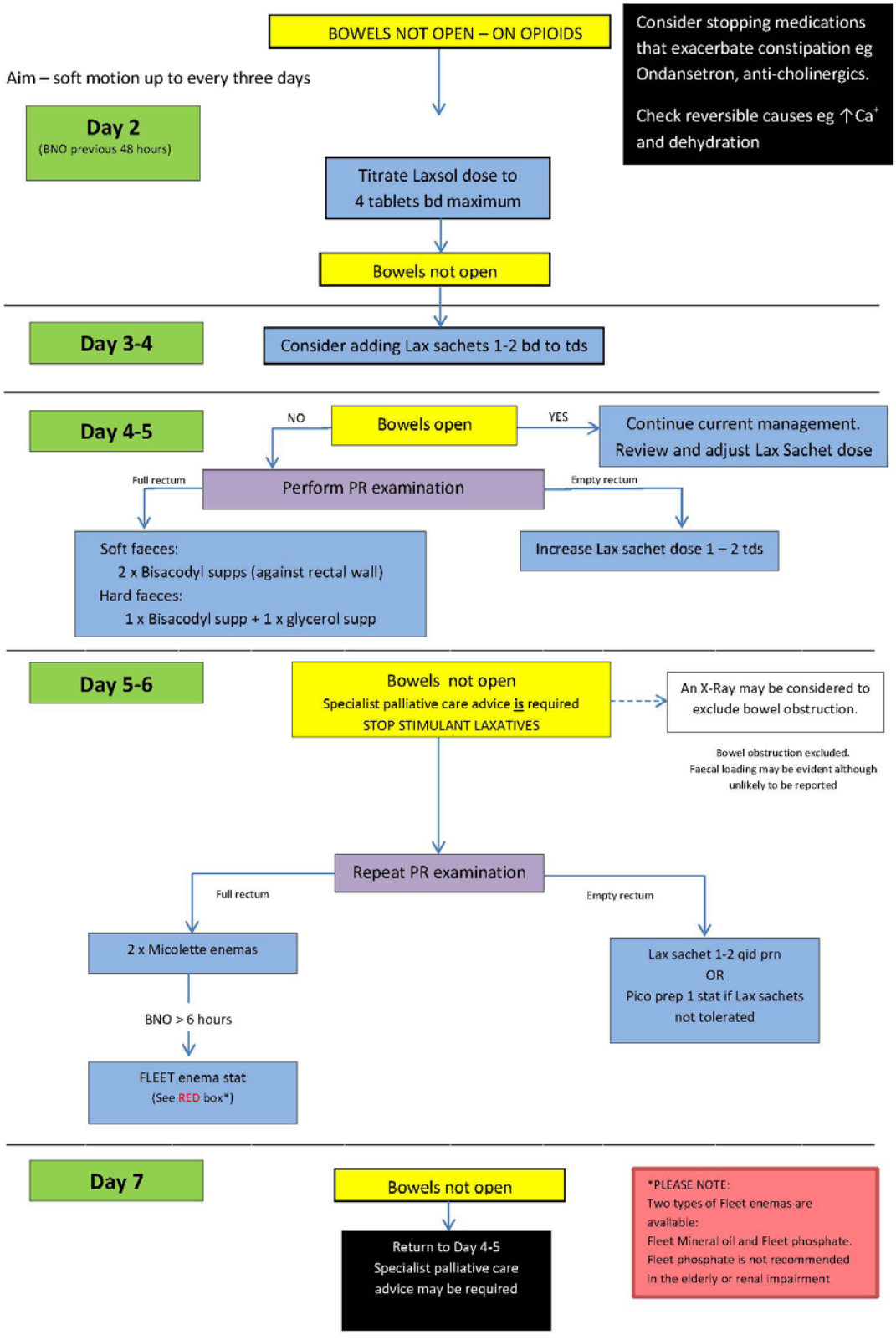
- Do digital rectal exam prior to administration
- Have resident lying left laterally with knees flexed if able
- Enemas should be at room temperature
- Use gravity not force to administer
- Please check electrolytes if more than 2 enemas are given

Administration of suppositories

- Do digital rectal exam prior to administration
- Medicated suppositories: Insert at least 4 cm into the rectum against rectal mucus membrane, administer lubricated blunt end first.
- For lubricating suppository, administer pointed end into faecal mass, allow 20 minutes to take effect.

CONSTIPATION

MANAGEMENT OF CONSTIPATION FOR RESIDENTS TAKING OPIOIDS



Reference: Adapted from PWIG (2017), with thanks to Canterbury District Health Board (Constipation Flowchart)