Establish resident's normal bowel pattern

Suspected constipation

Is this addressed in the individual care plan?

Implement Care Plan

Update Care Plan

Do not miss

Assess for:
- Acute abdominal pain & possible obstruction
- Delirium (see CAM assessment pg 12)
- Impaction (see DRE next page)
- Rectal bleeding

Contact GP who may follow up with one or more of the following investigations:
- Physical exam
- Rectal exam
- Abdominal x-rays
- Blood – FBC etc
- Stool sample

1st line treatment: (day 1-3)
Assess:
- Physical environment
- Seating position favourable for bowel movement
- Non invasive abdominal exam – bowel sounds, pain with light & deep touch, abdominal masses or lumps (notify GP if abnormal exam result)

Interventions:
- Dietary: porridge, prunes, kiwi fruit
- Increase fluid intake
- Laxatives: usually osmotic agent (Lactulose-Laxsol e.g. combination of both)
- Complementary treatment can be considered: essential oils, massage, reflexology
- Maintenance: increase exercise (walking is possible) or stationary exercise

2nd line treatment: (day 4)
Re assess:
- Non invasive abdominal exam – bowel sounds, pain with light & deep touch & abdominal masses or lumps (notify GP if abnormal exam result)
- Digital rectal exam (DRE) to assess for impaction

Interventions:
- Follow facility protocol and discuss with nursing leader &/or GP (e.g. glycerine suppository, Dulcolax, Movicol, Oral Fleet, enema, high enema, manual removal)

3rd line treatment: (day 5)
Re assess:
- Non invasive abdominal exam – bowel sounds, pain with light & deep touch & abdominal masses or lumps (notify GP if abnormal exam result)
- Digital rectal exam (DRE) to assess for impaction

Interventions:
- Follow facility protocol and discuss with nursing leader &/or GP (e.g. glycerine suppository, Dulcolax, Movicol, Oral Fleet, enema, high enema, manual removal)

Maintenance & prevention guidelines
- Assess & treat haemorrhoids and fistulae
- Provide adequate privacy
- Ensure adequate body positioning
- Provide enough time, preferably after meals
- Ensure adequate hydration, dietary intake, fibre/fluid balance
- Review medications – reduce constipating drugs

Abdominal assessment basics:
- Listen for bowel sounds over each quadrant:
  - Absent?
  - <2-3 per minute (hypoactive)
  - 10-30 per minute (hyperactive)
  - High, tinkling sounds in one area (possible obstruction)
- Lightly feel (palpate) abdomen:
  - Guarding with light touch?
- Deeper abdominal palpation:
  - Masses?
  - Tenderness or pain?
  - Note location

Listen for bowel sounds over each quadrant:

- Absent?
- <2-3 per minute (hypoactive)
- 10-30 per minute (hyperactive)
- High, tinkling sounds in one area (possible obstruction)

Lightly feel (palpate) abdomen:
- Guarding with light touch?

Deeper abdominal palpation:
- Masses?
- Tenderness or pain?
- Note location
Digital Rectal Examination (DRE)

- Obtain consent
- Observe area for haemorrhoids/rectal prolapse/tears
- Lying (L) lateral with knees flexed if able
- 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

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

ENEMAS & SUPPOSITORIES

Enemas should be at room temperature
Use gravity not force to administer
Please check electrolytes if more than 2 enemas are given

Administration of enema
- Do digital rectal exam prior to administration
- Have resident lying left laterally with knees flexed if able
- Medicated suppositories: Insert at least 4 cm into the rectum against rectal mucous membrane, administer lubricated blunt end first.
- For lubricating suppository, administer pointed end into faecal mass, allow 20 minutes to take effect.

Administration of suppositories

Types of drugs used for constipation:
1. Bulking agents (e.g., 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 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.

- 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.
- Stimulant (glycerol, bisacodyl) - must be inserted against the mucous membrane of the rectum, and not into the faecal mass
- Osmotic (rectal phosphates)
- Stool Softening (docusate sodium).

Side effects can include electrolyte imbalance and abdominal pain.

Diarrhoea – assess for the following:

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- Overuse of laxatives
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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