Constipation

Resident with suspected constipation
(see Recognising constipation - Practice point 1)

1. Check vital signs - review Recognition of the deteriorating resident.
2. Where the resident has a bowel management plan, follow the plan.
3. If not immediately life-threatening, review Checklist for contact and verbally contact GP*.

STABLE VITALS → Undertake Assessment of the resident with constipation (see Practice point 2)

UNSTABLE VITALS → Review advance care plan and refer to Management of residents with unstable vital signs

Identify and escalate Red flags for deterioration (see Practice point 3)

RED FLAGS PRESENT → Review advance care plan and refer to Management of residents with unstable vital signs

RED FLAGS ABSENT

Assess for Escalation criteria (see Practice point 4)

ESCALATION CRITERIA ABSENT → Implement non-pharmacological strategies (see Practice point 5)

Is the resident in last days of life?

NO

Credentialed practitioner to consider performing gentle digital rectal examination

YES / **ESCALATION CRITERIA PRESENT** → Refer to GP - at GP discretion:

- For residents on a palliative pathway, refer to resident's palliative care provider
- Refer to **HHS RaSS** at GP discretion

Digital rectal examination findings:

- Soft stool or small amount hard stool in rectum (see Practice point 6)
- Large, hard mass of stool in rectum (faecal impaction), (see Practice point 7)

BOWELS OPEN AND SYMPTOMS IMPROVE → With GP and resident, update or develop a bowel management plan

FAILS TO IMPROVE OR DEVELOPS ESCALATION CRITERIA → Refer to GP - at GP discretion:

- For residents on a palliative pathway, refer to resident's palliative care provider
- Refer to **HHS RaSS** at GP discretion

*Where timely, arrange telehealth or face-to-face GP review

Constipation practice points

1) Recognising constipation

Constipation should be suspected if the resident complains of constipation or has two or more of:

a. Fewer than three spontaneous bowel motions a week.

b. In more than 25% of bowel motions there is:

- Straining whilst attempting to pass a bowel motion or
- Lumpy or hard stools (Bristol Stool Form Scale 1 to 2) or
- Sensation by report of resident of incomplete evacuation of bowels or
- Sensation by report of resident of anorectal blockage or
- Manual manoeuvres required to facilitate passage of bowel motion, such as digital evacuation or support of the pelvic floor

Constipation should also be considered in residents with new onset small volume loose stools (Bristol Stool Form Scale 5 to 7) when infectious causes of diarrhoea have been excluded.

In residents with cognitive impairment or impaired communication, constipation may present with non-specific symptoms including:

- Agitation or changed behaviour
- Reduced oral intake
- Functional decline

2) Assessment of resident with constipation

The goals of assessment of the resident with constipation include to:

1. Confirm the diagnosis of constipation.
2. Identify the underlying cause of, or contributors to, constipation.

History

- Where a resident has reported constipation, ask what they mean by constipation?
- How long has the resident had symptoms?
- When was the last bowel motion?
- What was the consistency of the last motion?
- Did the resident need to use manual manoeuvres to facilitate passage of a bowel motion?
- Has there been a recent change to the resident's level of activity, function or diet / fluid intake?
- Is there any of the following symptoms:
  - Abdominal pain?
  - PR bleeding or passage of mucus with stool?
  - Inability to sense the urge to defecate?
  - Vomiting? If yes, how often?
- Is the resident currently, or were they previously, using laxatives - if yes, which type?
- Review medications for drugs that may cause constipation and cease or replace where able; medications that commonly cause constipation include:
  - Analgesics: Opioids, Non-steroidal anti-inflammatory drugs (NSAIDs)
  - Anti-nausea agents: Ondansetron
  - Antacids containing aluminium or calcium
  - Anticholinergics (e.g. tricyclic antidepressants, antipsychotics, antispasmodics, antihistamines, benztropine, oxybutynin)
  - Antidiarrhoeal agents
  - Antihypertensives including calcium-channel blockers, beta blockers and diuretics
  - Dopamine and dopamine receptor agonists
  - Iron and calcium supplements

Constipation practice points (cont'd)

2) Assessment of resident with constipation (cont'd)

Examination
Examine the abdomen for:

- Abdominal distension
- Abdominal masses
- Abdominal muscle strength
- Focal or generalised tenderness
- Guarding or rigidity

Examine the peri-anal area for local anorectal disorders such as hemorrhoids, rectal prolapse, fissures. Where indicated, credentialed clinicians may perform a rectal examination to assess for faecal impaction (a large, hard mass of stool in rectum), anal tone, masses or strictures.

Investigation
Investigations should be individualised to the resident's stage of life and in the absence of red flags or escalation symptoms, are generally only indicated in resident's with recurrent constipation or suspicion of underlying disease.

Initial investigations should include blood tests looking for:

1. Full blood count for Iron deficiency anaemia.
2. Electrolytes: hypocalcemia and hypercalcemia, hypokalaemia, hypomagnesemia.
3. Thyroid function tests for hypothyroidism.

3) Red flags in residents with constipation

If any of the following red flags are identified in residents who have constipation, review the resident's advance care plan, consult resident or substitute health decision maker (or nominated decision support person) and refer to Management of residents with unstable vital signs pathway.

The following are considered red flags in the resident with constipation:

- Vital signs in the red or danger zone - refer to Recognition of the deteriorating resident
- Recurrent vomiting unresponsive to antiemetic therapy
- Severe, unremitting abdominal pain

4) Escalation criteria in residents with constipation

First screen for red flags as above. Where there are no red flags, presences of any of the following may prompt escalation to **HHS RaSS** at GP discretion (or in residents nearing end of life, to the resident's palliative care provider) if any of:

1. Red flags in a resident who has conservative goals of care and does not wish to be transferred to hospital.
2. Severe pain on passage of bowel motion.
3. Rectal loss of blood or mucus.
4. Unintentional weight loss with acute change to bowel habit.
5. Failure to respond to therapy despite appropriate escalation of therapies.
6. Progressive abdominal distension.

Constipation practice points (cont'd)

5) Non-pharmacological management strategies for treatment and prevention of constipation

Institute a bowel management plan in consultation with resident and their GP - include consideration of:

- **Fluid:** Adequate fluid intake individualised to resident's comorbidities
- **Fibre:**
  - Adequate dietary fibre intake; a diet high in vegetables is recommended
  - Kiwi fruit - one kiwi per 30kg body weight per day increases frequency and ease of defecation; prunes or flaxseeds may also relieve symptoms of constipation
  - Pear juice or prune juice contain sorbitol and as such may have a benefit in constipation
  - Ingestion of a high fibre diet without sufficient fluid intake may contribute to faecal impaction
- **Exercise:** Encourage exercise tailored to resident's abilities and needs; where a resident is bed-bound, exercise may still assist in the form of pelvic tilt, low trunk rotation and single leg lifts
- **Toileting:**
  - Encourage toileting when residents have the urge to defecate; toilet each morning and thirty minutes after meals or after a hot drink when the gastrocolic reflex is maximal
  - Improve access to toileting facilities: ensure privacy and comfort; mobility assistance as required
  - Optimise positioning on toilet: sit with knees above hips - may require a foot support to raise feet; for bed-bound residents, lying on left side with knees bent towards the abdomen

6) Pharmacological management strategies for constipation

Individualise the approach, informed by contributors to constipation and the resident's preferences and:

- Stage of life
- Ability to safely swallow
- Existing medications

Introduce non-pharmacologic strategies (see Practice point 5), where appropriate. Institute step-wise approach individualised to resident - progress to next step only if no response within defined time to earlier step and as guided by the GP prescribing the medication:

- Add bulk-forming laxative e.g. psyllium (such as in Metamucil) - note: generally require intake with 250 mL liquid; **avoid bulk-forming laxatives if:**
  - Fluid restriction
  - Opioid associated constipation or faecal impaction (increase risk of bowel obstruction, especially if immobile / dehydrated)
- Add or substitute an osmotic laxative:
  - Polyethylene glycol (e.g. Movicol sachet), each sachet dissolved in 125 mL water (up to 2 to 3 sachets daily)
- Add or substitute a stimulant laxative (e.g. senna) - this may be available as a combination treatment such as docusate 50mg with senna 8mg (e.g. Coloxyl with senna) one to two tablets orally at night; stimulant laxatives are preferred in opioid induced constipation

7) Management of faecal impaction

Faecal impaction is diagnosed by symptoms of faecal soiling or overflow diarrhoea and rectal examination. It is important to note that the below approach may take a few days to achieve a result. GP to individualise approach appropriate to resident needs and preferences. Options include:

- Polyethylene glycol e.g. Movicol sachet, each sachet dissolved in 125 mL water, 4 to 8 sachets daily for up to 3 days (caution in heart failure) or
- Glycerol 2.8g suppository rectally - single dose only or
- Sorbitol + sodium citrate + sodium lauryl sulfoacetate enema (e.g. Microlax enema) - use only if Movicol and glycerol suppository have been ineffective; caution in use of saline laxatives in older persons is advised given risk of electrolyte disturbance and dehydration

Where these therapies are not effective, consider manual (digital) disimpaction by credentialed practitioner.

Constipation references

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Constipation version control

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