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CLINICAL GUIDELINE

Constipation Management Guidance for Community Nursing Staff

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

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Scope

This guidance gives community nurses advice on bowel assessment and the management of constipation in adults.

Nursing Staff Responsibilities

All nursing staff;

- Are responsible and accountable for their own practice in relation to the assessment and management of patient's with constipation (NMC Code of Conduct (2015)) NMC The Code, Royal Pharmaceutical Society Professional Guidance on the Administration of Medicine in Healthcare Settings (Jan 2019)
- Will initiate simple treatment and health promotion activities to prevent constipation and promote self-care.

Introduction

Constipation can be a symptom of many diseases and disorders. Bowel Assessment and the management of constipation can be a challenge for nurses. The importance of educating and training all members of the nursing team, including care home staff, in the management of bowel care is important. An evidence based approach using a clinical judgment tool, management of constipation flow chart, preventative and treatment guidelines should facilitate good practice across NHSGG&C.
If left untreated constipation may lead to rectal loading/ faecal impaction, or even faecal incontinence as a result of the impacted bowel.

Constipation requires immediate assessment if accompanied by symptoms of undiagnosed rectal bleeding, weight loss, abdominal pain and vomiting as may be indicative of colorectal cancer and it is advisable to seek guidance from your GP as soon as possible.

The SPHERE Bladder and Bowel Service

This team is responsible for delivering a high quality and cost-effective service within the resources available. The team aim to ensure that teams across NHS GGC have access to current evidence regarding promotion of continence and management of bladder and bowel dysfunction. SPHERE Service

A Definition of Constipation

Constipation is a symptom-based disorder, which describes defecation that is unsatisfactory because of infrequent stools, difficulty passing stools, or the sensation of incomplete emptying.

However, for some, constipation can most easily be defined as a variation in an individual's normal bowel function. People's perceptions of constipation vary greatly and normal bowel function may involve defecation three times daily or once every three days, but diagnosis may take place when there is a marked reduction in the amount of stools and/or reduced frequency of defecation.

Types of Constipation

- Chronic constipation usually describes symptoms which are present for at least three months.
- Faecal loading/impaction describes retention of faeces to the extent that spontaneous evacuation is unlikely.
- Overflow faecal incontinence is leakage of liquid stool from the proximal colon around impacted, where small quantities of stool may be passed frequently and without sensation.
- Functional (primary or idiopathic) constipation is chronic constipation without a known cause.
- Secondary (organic) constipation caused by medication or an underlying medical condition, including endocrine, metabolic, neurological or primary diseases of the colon.

Alarm Signs ("Red Flag") Symptoms

Referral for further investigation is essential if patients present with any of the following 'red flag' symptoms.

- Change in bowel habit from own normal pattern for more than 6 weeks.
- Undiagnosed rectal bleeding.
- Abdominal pain or discomfort.
- Tenesmus and incomplete emptying
- Tiredness
- Anaemia

Factors increasing the Risk of Suffering from Constipation? (This list is not exhaustive)

Social Factors

- Low fibre diet or low calorie intake.
- Difficult access to toilet facilities or changes in normal routine or lifestyle.
- Lack of exercise or reduced mobility.
- Limited privacy when using the toilet.
- Low educational levels or socio-economic deprivation.

Psychological Factors

- Anxiety and/or depression.
- Somatization disorders.
- Eating disorders.
- History of sexual abuse.

Physical Factors

- Female sex.
- Older age.
- Pyrexia, poor fluid intake/dehydration, immobility.
- Sitting position on a toilet seat (compared with the squatting position for defecation).

Causes of Constipation

There are a number of factors that can lead to, or cause constipation:

- A diet that is insufficient in or lacks adequate fibre.
- Insufficient fluid intake.
- Organically derived delay in colonic transit time.
- Evacuation difficulties caused by hard impacted stools or nerve damage.
- Anorectal conditions e.g., haemorrhoids or anal fissure, rectal prolapse, rectocele, anismus (contraction rather than relaxation of the anal sphincter), megacolon or megarectum.
- Bowel disorders such as inflammatory bowel disorder, Irritable Bowel Syndrome, diverticular disease and carcinoma.
- Surgical or diagnostic procedures, post-operative constipation.
- Habit or routine such as ignoring the desire to open bowels.
- Polypharmacy or any one medication likely to cause constipation.
- Spinal injury/disorders.
- Urinary problems.

Assessment of Constipation

Clinicians and trained Health Care Assistants should use this guideline alongside a full holistic assessment and Appendix 1 to guide them in the management of patients presenting with constipation Management of Lower Bowel Dysfunction, including DRE (RCN 2019).

Mention of Digital Rectal Examination (DRE) is included for completeness as following referral to the Community Nursing Team this technique may be required to further assist patient management. (Appendix 2)

DRE is the insertion of a lubricated, gloved finger into the anal canal and then rotated gently in a clockwise motion in order to ascertain the type of stool in the anal canal.

It can initiate stimulation of the bowel and thus elimination may occur naturally. Competence to perform this technique must be demonstrated before undertaking as per RCN Guidelines (2019) above link.

A DRE can be undertaken by a registered nurse who can demonstrate professional competence to the level determined by the Nursing and Midwifery Council (NMC) in its Code of professional conduct. The performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff. Such supervision should be documented and counter signed by the supervisory nurse as part of the induction/competency framework and held within the staff member's personal portfolio.

Nonpharmacological Management of Constipation

Standard advice is to increase fluid, fibre and exercise. It is not always possible to achieve this in frail elderly and immobile patients however where possible consider passive exercises, walking short distances, standing up from chair.

Look at the patient's dietary fibre intake using food record diary (Appendix 3) and fluid intake and advise accordingly. Use ideas regarding fibre intake and monitor outcome using the Bowel Movement Record together with food record diary. Assess patients nutritional status using the MUST Tool. If patient is undernourished follow the MUST Patient Pathway or consider involving dietitian for advice.

Elderly patients or those with learning disabilities may require the assistance of a relative or carer to manage their fibre and fluid intake and complete a Bowel Movement Chart on their behalf. In line with a person centred care approach patients/ clients and carers should be fully involved in a three way dialogue with the health care professional which ensures their wishes and the advocacy role is respected.

Fluid intake- use the BDA recommended fluid intake chart to determine appropriate fluid intake and encourage small quantities frequently.

Look at toileting aids to ensure stability and correct position on toilet - involve occupational therapist, use of raised toilet seats (can the person sit with their feet firmly on the floor, or is a step required), toilet frames to provide stability.

Discuss with patient what their normal triggers are for going to the toilet, such as first cup of coffee, or after breakfast, and help them to maintain or develop a routine where possible.

Consider liaising with dietitian, continence adviser and GP.

Ongoing monitoring should be a feature of good clinical care. Once effective management is established patients should be able, and be guided, to take responsibility for self- management by making adjustments to lifestyle as appropriate.

Pharmacological Management of Constipation

This guidance is based on NICE Scenario: Constipation in Adults (Jan 2024) for full guidance click here.

- Manage any underlying secondary cause of constipation, and advise the person to reduce or stop any drug treatment that may be causing or contributing to symptoms, if possible and appropriate.
- Advise on lifestyle measures, such as increasing dietary fibre, fluid intake, and activity levels.
- If these measures are ineffective, or symptoms do not respond adequately, offer treatment with oral laxatives using a stepped approach (see below – ctrl & click hyperlinks to view GGC Formulary choices in each class).
- In the case of chronic constipation (symptoms which are present for at least 12 weeks in the preceding six months) manage any faecal loading and/or impaction first, if present.
- Gradually titrate the laxative dose(s) up or down aiming to produce soft, formed stool without straining at least three times per week.
- See NICE guidance for advice on the management of pregnancy and breastfeeding.

Bulk forming laxatives	• **First line**- offer a bulk forming laxative e.g. ispaghula, (unless constipation is opioid induced - see box below) • Note - while taking bulk forming laxatives, it is important for the person to drink an adequate fluid intake

If stools remain hard or difficult to pass, then move on to

Osmotic laxatives	• **Second line** - add **or** switch to an osmotic laxative e.g. macrogol or lactulose

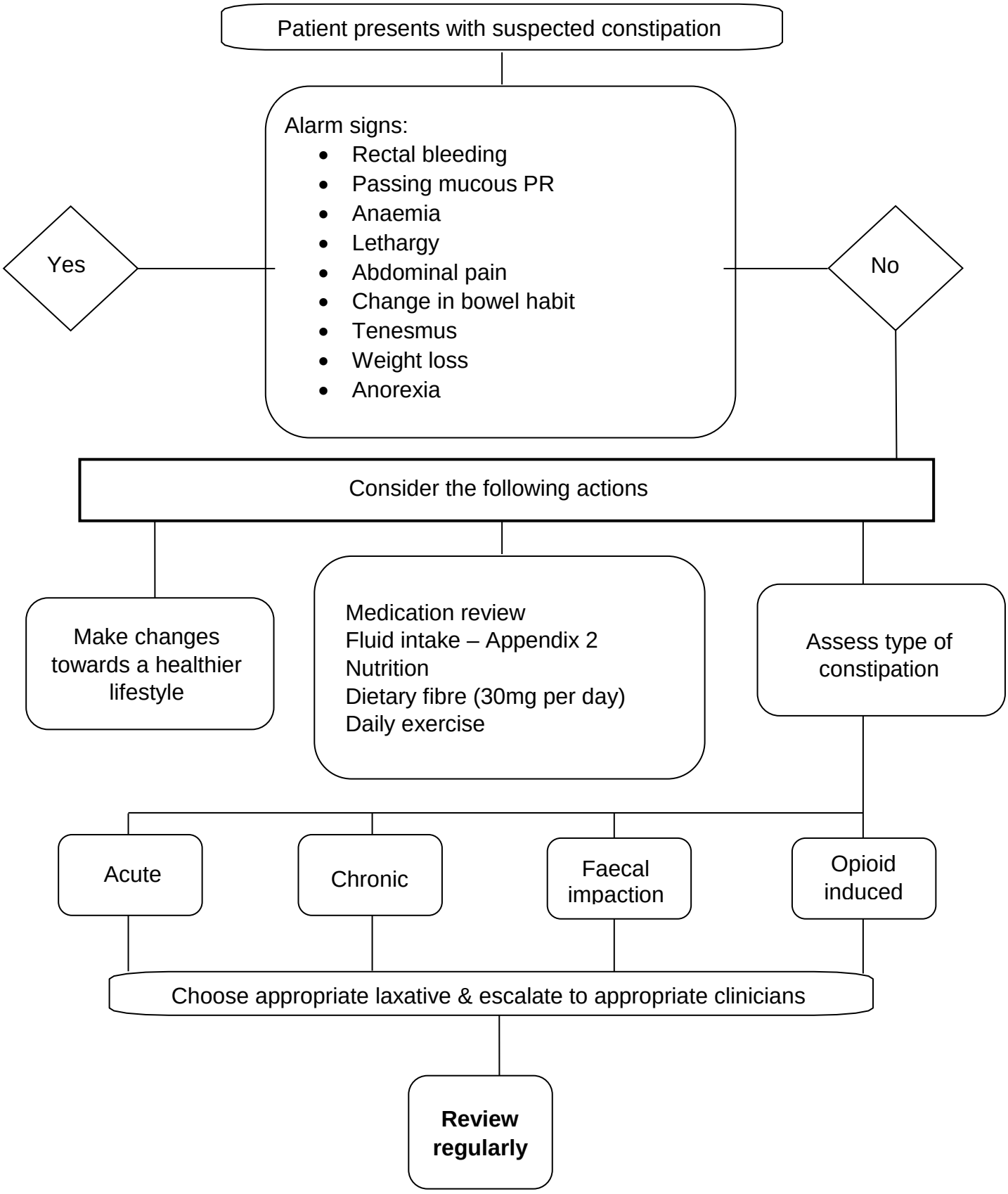
If stools are soft but difficult to pass, or there is a sensation of inadequate emptying, then move on to

Stimulant laxatives	• **Third line** – add a stimulant laxative e.g. senna
Opioid induced constipation	• Do not prescribe bulk-forming laxatives • Offer an osmotic laxative **and** a stimulant laxative • For information on the management of constipation in palliative care please refer to Scottish Palliative Care Guidelines

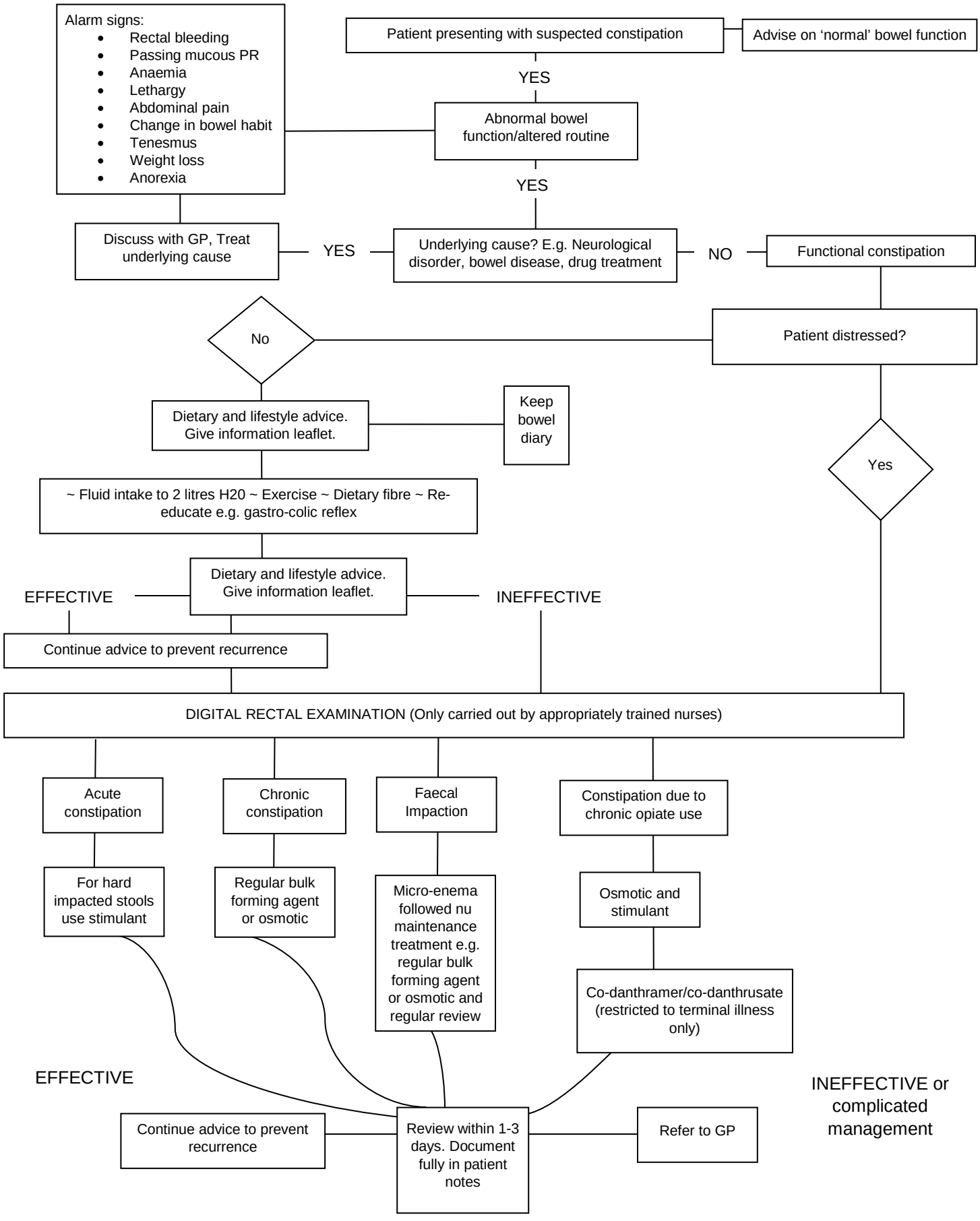
Note: For advice on patients with swallowing difficulties, nasogastric or RIG/PEG tubes please contact primary care pharmacist or enteral feeding teams.

For further information on doses, contraindications and side effects, refer to the summary of characteristics at Electronic Medicines Compendium or BNF

Assessment and Management of Constipation Flowchart General (Appendix 1)



Management of Adult Constipation for Nurses competent in DRE (Appendix 2)



Appendix 3 Food and Fluid record diary

Name_____ **CHI** _____

Week beginning	**Food**				**Fluid**				Comments
Day	Breakfast	Lunch	Dinner	Snacks	Tea	Coffee	Water	Other	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									