Managing constipation in residential care

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Key Points

Constipation is a major problem in residential care

Early detection and prevention is key to management of this common condition

All staff have a duty to assess their resident's bowel habitus, they must identify potential changes in treatments which could cause constipation.

Effective routines in managing elimination are essential to prevent constipation.

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Constipation is a major problem in residential care. It is a condition which, if left untreated, can result in major distress and health problems for sufferers. If the condition is not detected early, then resultant interventions become increasingly complex and costly, meaning staff spend time and resources managing what could have been, a simple problem. This paper seeks to define and identify the main causes of constipation in residential care settings. It evaluates lifestyle approaches to prevention which are relevant to residential care and provides information on early detection and strategies to manage the condition. Finally, a 'red flag' table is identified which will support carers and nurses to identify how constipation may be an early warning sign for more complex health conditions.

What is 'constipation'?

Constipation is defined generally, as a passage of stools less frequently than usual (Keenan, 2012). The diagnosis can be contentious, as there is a lack of consensus opinion on 'usual habits' for bowel movements. As a consequence, clinicians must rely on self-reporting or signs and symptoms. These tend to only manifest when the issue has worsened to requiring active forms of intervention and management. Constipation occurs more frequently in females and the elderly and is a significant factor in residential settings (Higgins & Johanson, 2004, Gallagher et al, 2008). Not only can it be painful to the sufferer, but it can impact significantly on quality of life (Dennison, 2005). Management of constipation is costly to the NHS (Maxion-Bergemann et al (2006). There are guidelines which support diagnosis of constipation, but these are limited to chronic constipation. Rome111 offers a criteria for diagnosis of chronic constipation which may be useful in determining whether longer term management is required (Longstreth, 2005) - see figure 1.

Presence of 2 or more of the following symptoms:	**Tick**
Straining during at least 25% defaecations	
Lumpy / hard stools in at least 25% defaecations	
Sensation of incomplete evacuations for at least 25% defaecations	
Sensation of anorectal obstruction or blockage in at least 25% defaecations	
Manual manoeuvres to facilitate at least 25% defaecations	
Fewer than 3 bowel movements per week	
*** Criteria fulfilled for the last three months with symptom onset at least six months prior to diagnosis**	

Figure 1 Rome 111 Criteria

Main causes of constipation

There are dietary and lifestyle factors which may precipitate constipation (Nice, 2015). These are in addition to underlying clinical conditions and certain medicines. The process of ageing has a major impact many physiological systems which causes an increased propensity to constipation (Lee, 2015). There are many causes of constipation in the elderly and the residential care staff must be aware of some of the more common causes, so that they can be

alert to the possibility of this condition in certain patients. Figure 2 lists the more common causes, however this is not an exhaustive inventory.

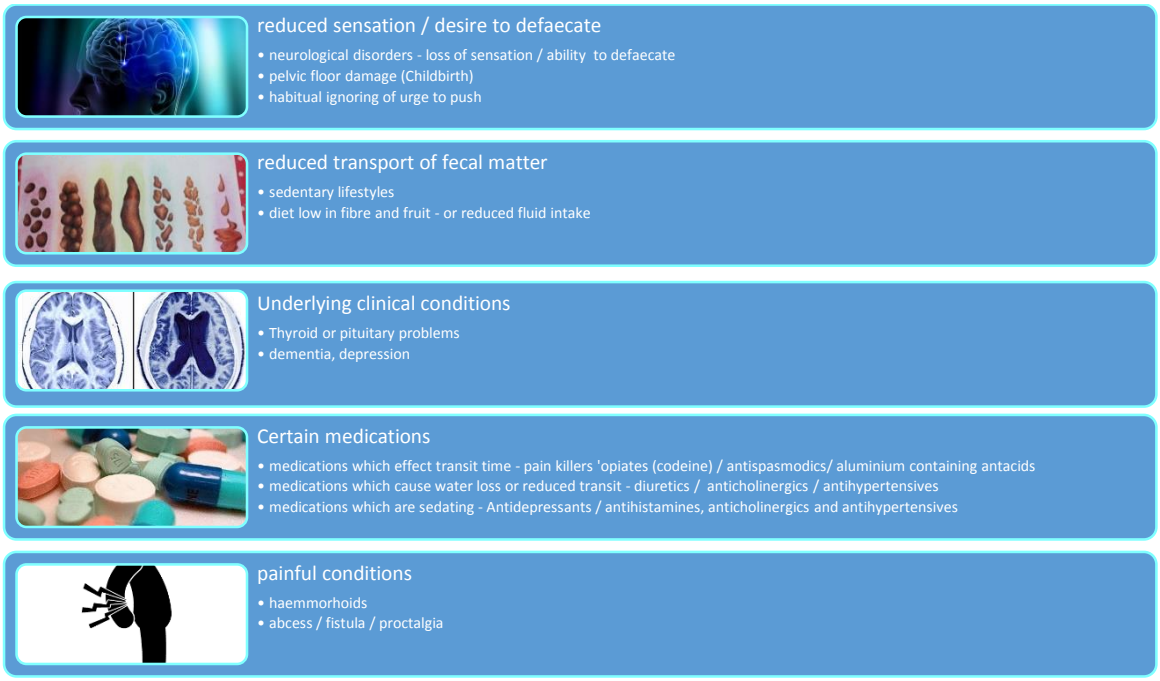

Figure 2 Causes of constipation

Identifying constipation in the elderly

A regular assessment and health history for residents in care settings can elicit very salient information in order to predict constipation. Alerts can be developed for those residents who have underlying conditions or medication regimes which have the potential to cause constipation. However, staff also need to be alert to the signs and symptoms which may preclude the diagnosis.

Constipation can present with excessive flatus, discomfort, infrequent bowel movements. The person may report passing hard stools or feeling ‘bloated’ (NICE, 2015). There may be feelings of incomplete evacuation, sufferers may be irritable, lack appetite or have general malaise (NIHSCB, 2012). In residential care settings, staff must be alert to residents who begin presenting to the toilet more frequently. Or whose appetite, affect or mood has changed recently. They can use the Bristol stool chart to identify type of stools passed. The Bristol stool chart is the usual scale for assessment and facilitates a consensus opinion on typing of stools (see Figure 3). Managing this condition can be embarrassing for the resident, so respectful conversations and articulate, professional approaches are essential to maintain concordance with treatments and management strategies.

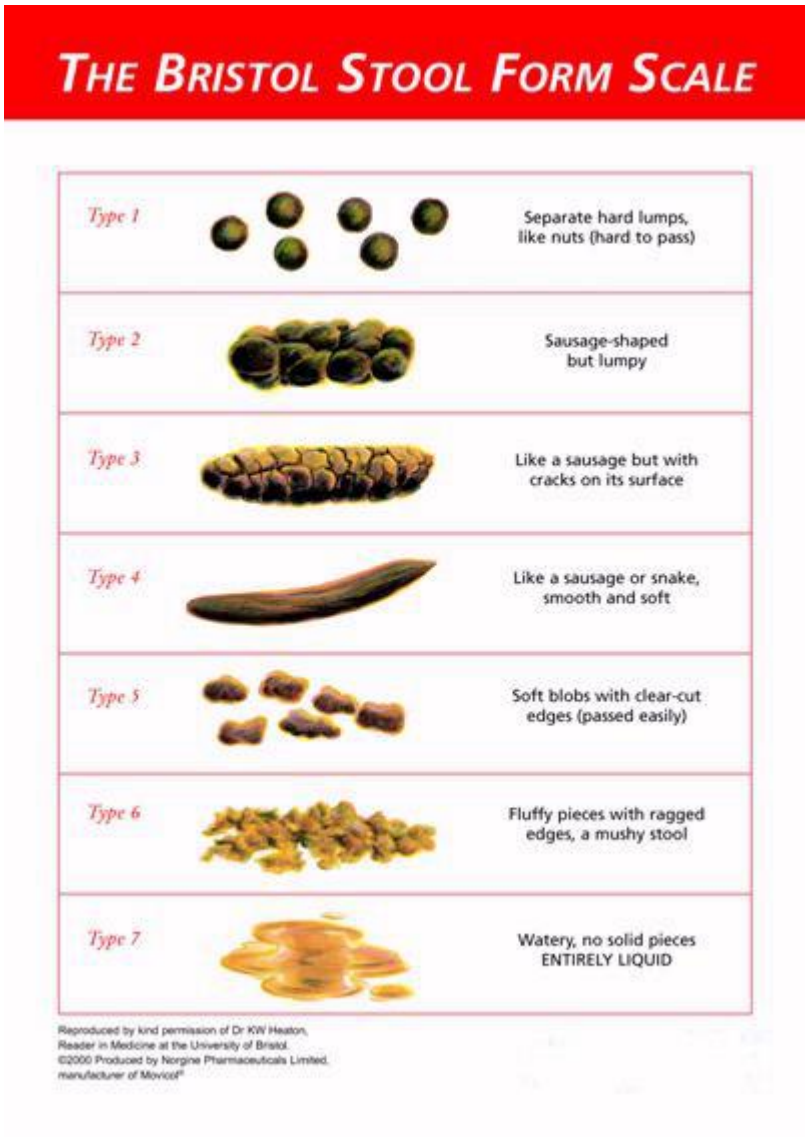

Figure 3 Bristol Stool Chart

Preventing constipation in the elderly.

The main way to combat constipation is through preventive measures. Regular monitoring of this issue can significantly impact upon subsequent treatment. The longer the constipation remains untreated, the worse the condition becomes and subsequently, more aggressive treatment is required. As adjunct to regular monitoring and early detection of constipation, NICE (2015) have identified strategies for prevention.

To combat reduction in transport of faecal matter, there are a number of dietary and lifestyle interventions which may assist. Increasing the dietary fibre remains contentious as a treatment for constipation. They may also cause harm. Rapid increases in fibre intake are associated with reduced absorption of micronutrients and will cause bloating and flatulence (Badali et al (1995). Increasing sorbitol rich fruit intake will stimulate bowel movements.

Sorbitol is a sugar alcohol which draws water into the large intestine to cause bowel movements (NICE, 2015). Ensuring all residents have a good fluid intake will reduce dehydration which is a major cause of constipation. Increasing activity remains contentious as a beneficial lifestyle change. In young healthy adults, exercise and increase in activity shows no proven benefits for managing chronic constipation (Annells & Koch, 2003). However, aged related research identifies inactivity can reduce colonic transit time and induce constipation (Costillia & Foxx-Orenstein, 2014). Any changes in activity would also be dependant upon the resident's functional capacity and ability to mobilise.

Regular toileting regimes have been evaluated as effective in maintaining good bowel habits. NICE guidance suggests that toileting should be unhurried (NICE, 2015). It is essential that residents are allowed time on the toilet. This occurs most frequently 30 minutes after a meal, or first thing in the morning after waking (Sherwood, 2012). People need privacy in order to relax, so staff must be aware of how to manage this safely and effectively for each patient. When a resident identifies a need to defecate, the response must be immediate, as evidence supports that hesitation can exacerbate constipation as faecal matter is retained in the bowels and more water is systemically absorbed.

Recordkeeping is essential in any residential care setting and any new diagnoses, medication regimes or factors which may cause an impact on the resident's ability to defecate must be adequately monitored and recorded. Discussions between staff at handover should report any of these changes so that monitoring may occur.

There are certain 'red flags', or symptoms which may signal underlying pathology which requires urgent review (NICE, 2005, NPS, 2011). These are detailed in figure 4.

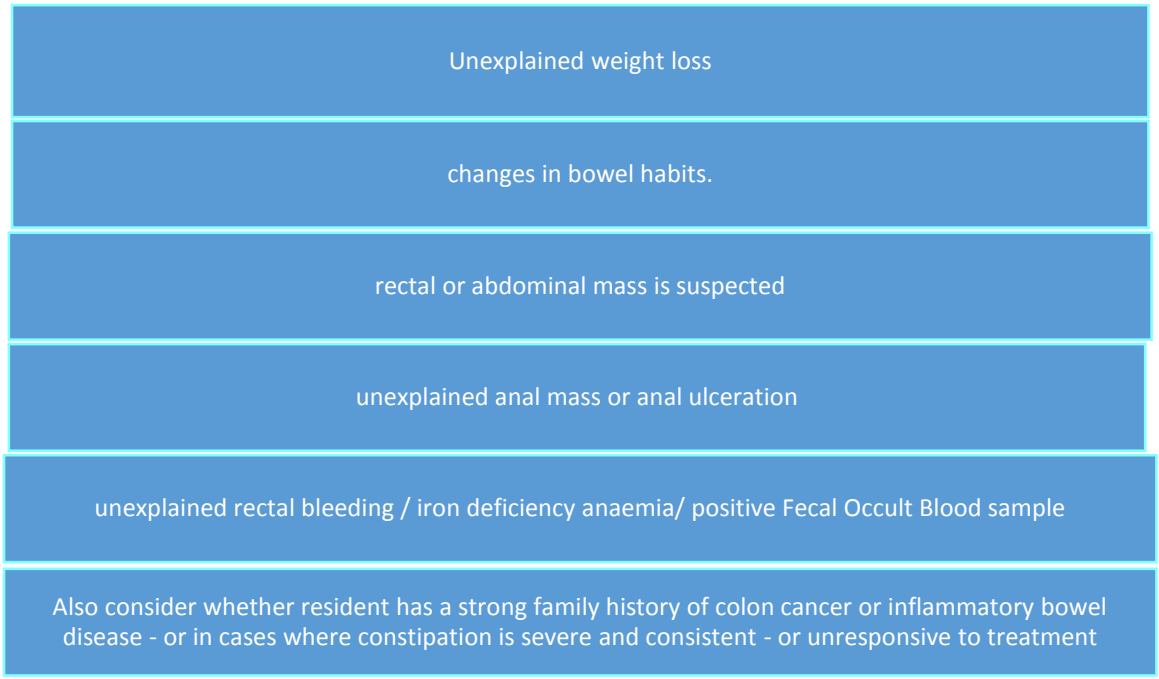

FIG 4 adapted from NICE (2015) NG12 Suspected cancer: recognition and referral available at https://www.nice.org.uk/guidance/NG12/chapter/1-Recommendations-organised-by-site-of-cancer#lower-gastrointestinal-tract-cancers [accessed 062016]

Treatment of constipation

Bulking agents and osmotic laxatives are usually medicines which are ingested orally. They work in slightly different ways to retain water and provide 'bulk' in the stool. The usual movement of stool through the gut is stimulated as a result of the larger bulk. Softeners change the stool consistency, enabling easier passage of faecal matter through the gut. Stimulant laxatives work on the gut, increasing intestinal activity and motility to expel the stool more rapidly.

Enemas and suppositories work as agents to relieve any impaction which may occur as a result of constipation. There are many types of enemas and suppositories. They may be irritant to the bowel, so that peristalsis is induced and faeces expelled, or they may work to soften faeces for easier passage.

Conclusion

This paper presented an overview of constipation aimed to staff working within residential care. The importance of predicting residents with a propensity to constipation, of early detection and rapid management is paramount. Constipation, if detected early enough, can be treated quickly and efficiently, with minimal disruption to staff and residents. However, if left unchecked, it can exacerbate to a level which requires significant resources, time and attention for management. All staff have a responsibility to manage this preventable condition and care for residents' needs regarding elimination in a sympathetic manner.

References

Annells, M., Koch, T. (2003) Constipation and the preached trio; diet, fluid intake, exercise. *International Journal of Nursing Studies*. 40, 843-852.

Badiali, D., Corazziari, E., Habib, F. I., et al. (1995) Effect of wheat bran in treatment of chronic nonorganic constipation. A double blind controlled trial. *Digestive Diseases in Science* 40: 349-356.

Costilla, V., Foxx-Orenstein, A. (2014) Constipation – Understanding the Mechanisms and Management. *Clinics in geriatric medicine* 30 107-115.

Dennison, C., Prasad, M., Lloyd, A., Bhattacharyya, S.K., Coyne, K. (2005). The health-related quality of life and economic burden of constipation. *Pharmacoeconomics.* 2005; 23: 461-476.

Gallagher, P. F., O'Mahony, D. and Quigley, E. M. (2008) Management of chronic constipation in the elderly. *Drugs Aging.* 25, 807-821.

Higgins, P. D. and Johanson, J. F. (2004) Epidemiology of constipation in North America: a systematic review. *American Journal of Gastroenterology*. 99, 750-759.

Keenan, L (2012) **COMPASS Therapeutic Notes on the Management of Chronic Constipation in Primary Care.** Northern Ireland Health and Social Care Board (NIHSCB). Belfast: Queens Printer and Controller of HMSO available at http://www.medicinesni.com/assets/COMPASS/constipation.pdf [accessed 0616]

Lee, A (2015) Combatting the causes of constipation *Nursing and residential care* (17) 6 198-202

Longstreth GF, Wilson A, Knight K, et al. (2003) Irritable bowel syndrome, health care use, and costs: a U.S. managed care perspective *American Journal of Gastroenterology*. 98, 600–607.

Maxion-Bergemann S, Thielecke F, Abel F, Bergemann R. (2006) Costs of irritable bowel syndrome in the UK and US. *Pharmacoeconomics*. 24, 21–37

Mounsey, A. Raleigh, M. Wilson, A. (2015) Management of constipation in older adults *American Family Physician*. 92 (6) p500-504.

National Prescribing Centre. (2011) '*The management of constipation' MeReC Bulletin*, 21, 2.

National Institute for Health and Care Excellence (NICEa, 2015) Clinical Knowledge Summary: Constipation, scenario Adults Available at; http://cks.nice.org.uk/constipation#!scenario [accessed 062016]

National Institute for Health and Care Excellence (NICEa, 2015) Clinical Knowledge Summary: Constipation, scenario pregnancy and breastfeeding - recommendation 12 dietary advice available at ; http://cks.nice.org.uk/constipation#!scenario [accessed 062016]

NICE (2015) NG12: Suspected cancer: recognition and referral. Available at ; https://www.nice.org.uk/guidance/NG12/chapter/1-Recommendations-organised-by-site-of-cancer#lower-gastrointestinal-tract-cancers [accessed 062016]

Sherwood, L *Fundamentals of Human Physiology (4th Ed)* California: Brooks Cole .