Violet's story

Opioid-related harm - "I wished I was dead"

This story has been taken from a patient interview and review of her health record.

In-patient experience

Violet is a 60-year-old female admitted acutely on 29 September 2015 from the emergency department to the operating theatre with severe abdominal pain and small bowel obstruction. A laparotomy and adhesiolysis was performed – bowel slightly twisted but no ischaemia.

She had an uneventful recovery in the post-anaesthesia care unit – a fentanyl patient-controlled analgesia (PCA) was commenced and she was transferred to a surgical ward for post-operative care.

Violet remained in hospital for six days. The PCA was taken down on day two and morphine sulphate immediate release/tramadol (taken as required) were charted and regularly administered for pain control. No laxative was co-prescribed. Laxsol (docusate + sennoside) was commenced (nurse initiated) on the night before discharge, after Violet requested this for increasing discomfort and constipation.

Violet ordered prunes every day, ensured she drunk 'untold' water and mobilised to her maximum capacity every day from the first day post-operatively. She did not receive any education on opioids/constipation while an in-patient.

Bowel movement was recorded each shift by the allocated registered nurse (RN) in Violet's health record (no stamp was utilised in the ward as this stage). No description was recorded of one bowel movement 12 hours prior to discharge despite Violet reporting to the RN that her bowel motion was 'one small, hard marble' and she still felt like she was 'bound up with concrete'.

On the morning of discharge Violet again reported her constipation to the surgical team on their morning ward round. The response was to use two glycerine suppositories and go home with a script for laxatives (at last they were charted!). Violet was given these to self-administer but was unable to place them due to the degree of constipation and when returned to her bed space 'pale and sweaty' was told to rest. At this stage she had 'had enough' and decided to go home as her discharge papers were ready and she felt things might improve at home. The RN suggested if she had no resolution from her constipation after discharge she could buy an enema at the chemist.

Outpatient experience

Violet returned home with her husband the first day of discharge and went straight to bed exhausted.

The next day she tried to resume mobilising and to eat but was extremely nauseated and her abdomen was very bloated and uncomfortable. Her bowels had still not moved despite taking Laxsol as prescribed since discharge and she said she felt the build up getting 'bigger and bigger'.

She sent her husband to the local chemist to buy an enema (she said she feels now she can never face up to going there again).

Violet described the following two hours as a time when she 'wished she was dead' from the time she had to ask her husband to administer the enema, to being petrified it would not work and she would have to go to ED for a manual removal, to sitting on the toilet screaming for an hour while holding a pillow over her abdominal wound, to finally passing a motion and then fainting.

She and her husband were 'extremely traumatised' and Violet remains upset and tearful when recounting this period of time.

For the next 2–3 days she was too scared to eat anything other than fruit and water and still feels frightened the constipation may return.

She is now back at work on reduced hours but feels her recovery time would have been decreased if she had not suffered from constipation post-operatively. Violet believes what was already a very traumatic experience rushing to ED in the middle of the night and then to the operating theatre was made into 'a nightmare' by her experience of opioid-related constipation.

Learning points

- Co-prescribing laxatives with opioids is essential to minimise constipation.
- Targeted patient education can never be underestimated in reducing harm from opioids.
- Description of bowel movement (preferably utilising a standardised tool like Bristol Stool Chart) is as important as recording the actual action.
- Once constipation is identified – treat it promptly and prior to discharge.
- LISTEN to the patient – they provide the most accurate individual assessment of constipation.