Constipation and gastrointestinal | Te kōroke me te puku-kōpiro

Maintenance and prevention guidelines

- Assess and 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 medication, 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.

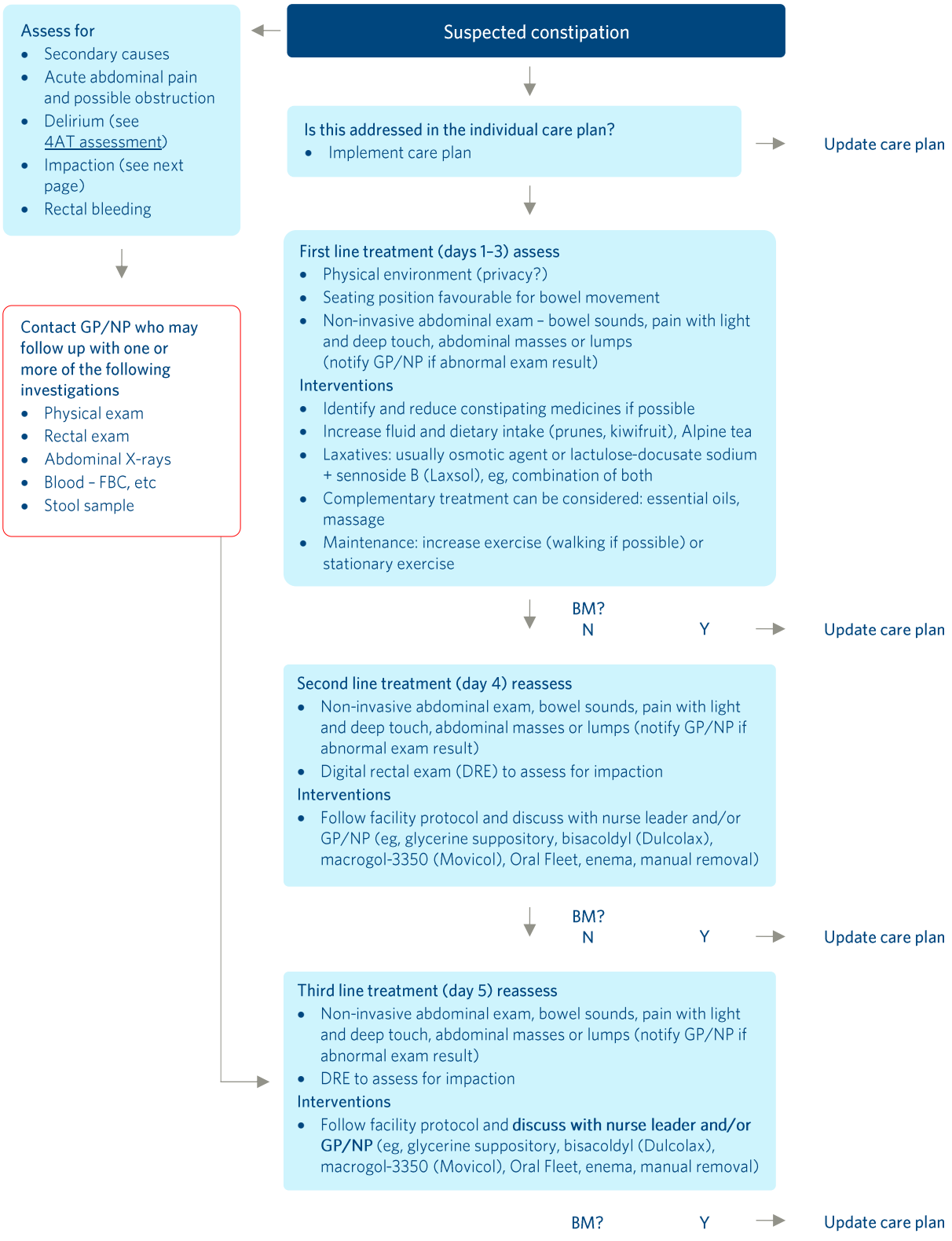
Remember to check for overflow

History of constipation and new, loose or watery stool is likely overflow.

Tip

For consistent constipation use a **regular** dose of laxative at the lowest dose that works rather than PRN.

Establish resident's normal bowel pattern



Medication overview

Types of medication used for constipation

Bulking agents, eg, psyllium husk powder (Bonvit, Konsyl-D) – increases faecal mass, which stimulates peristalsis, good for maintenance:

- Requires adequate fluid intake at the time of administration – one full glass of water.
- These agents require 2–3 days to exert their effect and are not suitable for acute relief.
- Avoid if possible in certain conditions, eg, late stage Parkinson's disease, stroke or spinal injury and existing faecal impaction or bowel obstruction.

Osmotic agents, eg, lactulose, macrogols (Molaxole) – promotes secretion of water into the colon, increases frequency of defecation, reduces straining:

- Often the first choice for constipation because they are gentle with few side effects.
- May take a few days to work because it affects the large bowel.

Stool softeners, eg, docusate – reduces stool surface tension leading to increased water penetration:

- 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.

Stimulants, eg, senna, bisacodyl – increases intestinal motility and colonic secretions:

- Use sparingly because it can result in electrolyte imbalance and abdominal pain.
- Prolonged use and hypokalaemia in rare cases can precipitate lack of colon muscle tone.
- Contraindicated in suspected intestinal blockages.
- Use with opioids.

Suppositories/enemas – medicated suppositories should be inserted blunt end first, lubricant suppositories should be inserted pointed end first:

- Lubricated (glycerine): lubricate anorectum, has 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 into the mucus membrane of the rectum and NOT into the faecal mass.
- Osmotic (rectal phosphates): rectal sodium citrate (Micolette enema), phosphate sodium dibasic (Fleet enema).
- Stool softening (docusate sodium): side effects can include electrolyte imbalance and abdominal pain.

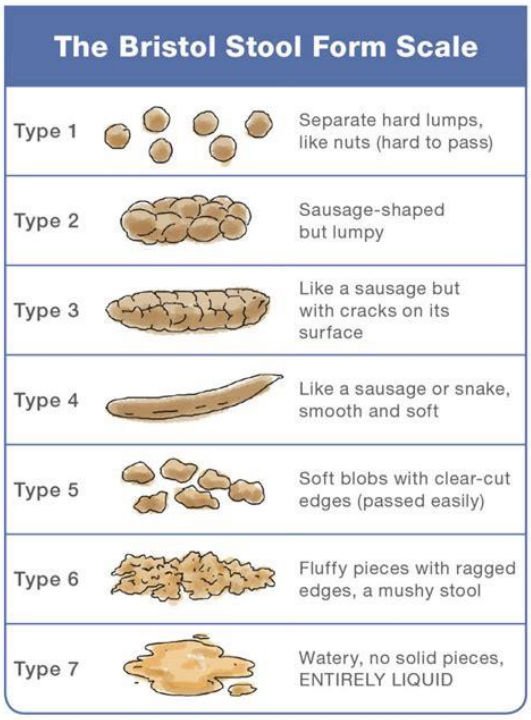
Enemas and suppositories

Administration of enema:

- Do digital rectal exam prior to administration.
- Have resident lying left laterally with knees flexed if able.
- Enemas should be at room temperature.
- Use gravity, not force, to administer.
- Please check electrolytes if more than two enemas are given.

Administration of suppositories:

- Do digital rectal exam prior to administration.
- Medical suppositories: insert at least 4 cm into the rectum against rectal mucus membrane, administer lubricant blunt end first.
- For lubricated suppository, administer pointed and into faecal mass, allow 20 minutes to take effect.



Diarrhoea

Assess the following:

- Self limiting, sudden onset diarrhoea
- Food poisoning
- Overflow related to constipation (see DRE guidelines next column)
- Pre-existing medical condition causing diarrhoea
- Overuse of laxatives
- *C. difficile* (potentially serious) – recent antibiotics?
- Treatment: monitor volume and estimate fluid loss and rehydrate
- If symptoms persist (> 3 days duration) request GP/NP assessment.

Digital rectal examination (DRE)

- Obtain consent.
- Observe area for haemorrhoids/faecal prolapse/tears.
- Lying left laterally with knees flexed if able.
- Gloved index finger well lubricated.
- Gently using one finger only.

Manual removal

- Should be avoided if possible and only used if all other methods have failed (or if part of the individual care plan).
- Obtain consent.
- Lying in left lateral position.
- Observe for haemorrhoids/rectal prolapse/tears.
- Take pulse as a baseline.
- Gently use one well lubricated gloved finger.
- Remove small amount at a time and stop if patient is distressed or pulse rate drops.

Bibliography | Te rārangi pukapuka

Constipation and gastrointestinal

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