Constipation
Kōroke

The information in this guide is accurate to the best of our knowledge as of June 2023.

Definition

Constipation describes a set of difficulties associated with defecation that a person experiences more than a quarter of the time. These difficulties include hard, lumpy, difficult-to-pass stools, straining, the feeling of incomplete emptying, infrequent bowel opening (fewer than three times a week without laxatives) and the need to manually assist defecation. Constipation may be acute (lasting less than one week) or chronic (lasting for three months or more). The need for regular aperients (laxatives) is diagnostic for underlying constipation (Aziz et al 2020).

Key points

- Constipation occurs in up to half of all people living in aged residential care (De Giorgio et al 2015; Mounsey et al 2015).
- Chronic constipation is best managed with a long-term plan and ongoing review.

Why this is important

Constipation has a significant impact on quality of life. While nurses in aged residential care commonly manage the problem, it can also progress to a bowel obstruction – a **life-threatening condition**.

Implications for kaumātua*

Some kaumātua may experience a sense of **whakamā** (shame, embarrassment) about their constipation and therefore not disclose their difficulty in passing stools. One reason for this may be that the kaumātua is a private person so finds it difficult to discuss such topics. See the *Guide for health professionals caring for kaumātua | Kupu arataki mō te manaaki kaumātua* for more information.

It is essential to give kaumātua and whānau/family all the information they need to fully participate and engage in preventative interventions and treatment. This might include explaining the importance of physical exercise, fibre-rich food and adequate hydration, and supporting appealing options that align with cultural preferences (eg, **kapa haka** to keep active, consuming kiwifruit products or traditional **Māori** herbal remedies).

* Kaumātua are individuals and their connection with culture varies. This guide provides a starting point for a conversation about some key cultural concepts with kaumātua and their whānau/family. It is not an exhaustive list; nor does it apply to every person who identifies as Māori. It remains important to avoid assuming all concepts apply to everyone and to allow care to be person and whānau/family led.

Using familiar, culturally acceptable terms when discussing constipation and bowel habit may help the kaumātua to communicate more freely.

Kupu (words) to discuss constipation

Māori term and pronunciation	English translation
Tūtae, **hamuti**	Stool, faeces
Tiko	Defecate
Turuturu	Leak
Kope	Pad
Wharepaku	Toilet
Uaua	Difficult
Maro	Hard
Ngohengohe	Soft, pliable

Assessment

The caregiver is often the one who identifies constipation. It is the nurse's responsibility to respond to that report using a diagnostic reasoning process: taking the history, conducting a physical examination and often treating with prescribed 'as needed' (PRN) medication. As part of this process, it is important to:

- assess bowel habit with the Bristol stool chart
- distinguish between constipation and bowel obstruction (potentially life threatening) and recognise any need for referral
- consider likely causes of constipation
- have a good knowledge of the different laxatives available (see table in 'Laxatives' section) to administer PRN treatment successfully.

Treatment

Constipation: population approach

1. Avoid constipation (Aziz et al 2020).
    a. Provide fluid rounds to encourage intake.
    b. Provide additional fluid support on hot days.
    c. Build regular physical activity into facility routines.
    d. Undertake routine dietary review of facility menu for fibre and stimulant content.

Constipation: individual approach

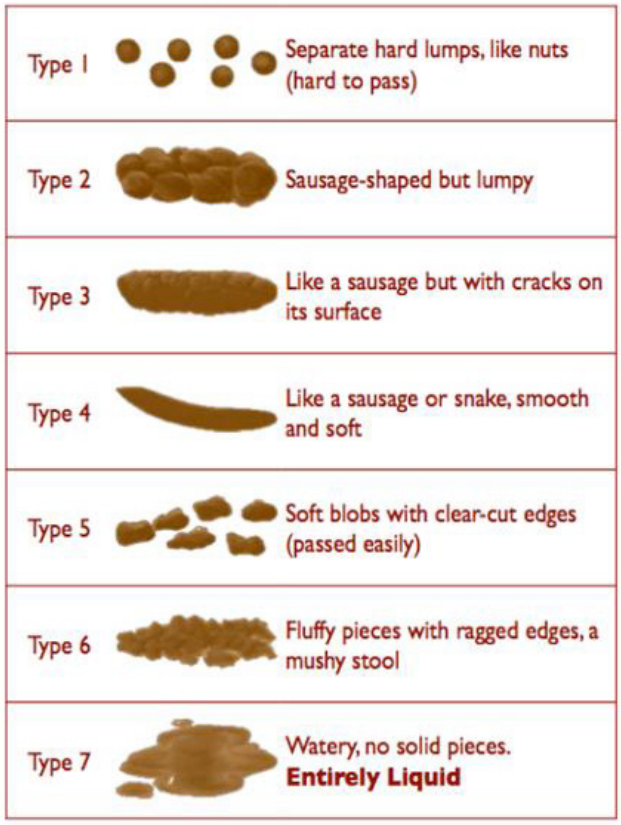
1. Avoid constipation.
    a. Assess and address key causes of constipation.
    b. Consider appropriate laxative management.
    c. Discuss laxative management with prescriber: regular laxatives may be required.
    d. Monitor bowel function to titrate laxative.
2. Treat acute constipation.
    a. Assess and address key causes of constipation: consider recent changes.
    b. Consider appropriate laxative selection from PRN medication.
    c. Escalate to general practitioner (GP) or nurse practitioner (NP) if acute constipation is not resolved in three days.
    d. Monitor bowel function to titrate laxative.
3. **Be aware of risk of bowel obstruction**. Severe constipation can evolve into a bowel obstruction, which is a clinical emergency that requires urgent assessment.
    a. A cognitively impaired resident may not report or may not be able to report bowel function. If their behaviours change, investigate for constipation.
    b. Where a resident has episodes of loose bowel motions, assess for severe constipation with overflow.
    c. When assessing nausea, vomiting or abdominal pain, always investigate bowel function as well.

Care planning

In the care plan, include:

1. fluid intake, adjusted during warm weather
2. physical activity as tolerated (including incidental walking, eg, to toilet)
3. individual dietary supplements (eg, dried fruit, grapes)
4. selection of fibre-rich food from standard menu (eg, porridge rather than toast for breakfast)
5. regular and PRN laxatives.

Bristol stool chart



Source: **www.continence.org.au/bristol-stool-chart**

Laxatives

Do not give laxative if you suspect a bowel obstruction

Laxative type	Examples and key information
Osmotic laxative Pulls fluid into the large bowel or retains fluid in large bowel. Stool is softened. Takes 24–96 hours to work as it must reach the large bowel to have an effect (bpac^{nz} 2019).	• Macrogol (Molaxole) may cause more diarrhoea than lactulose, but less gas (bpac^{nz} 2019). Can be used for faecal impaction. Is more effective than lactulose (Mounsey et al 2015). • Lactulose (laveac) is generally safe but may cause bloating, gas and loose stools (Aziz et al 2020).
Bulk forming laxative Increases stool size and stimulates peristalsis.	• Psyllium husk (Konsyl-D). Must be taken with ≥ 500 mL fluid. Onset of action is 12–72 hours. • Because of increased risk of bowel obstruction, do not give to residents who: – are on fluid restriction (bpac^{nz} 2019) – are taking opioids – have Parkinson's disease, stroke or paraplegia or other conditions that slow bowel transit.
Stimulant laxative Increases gut movement. Can cause abdominal cramp (New Zealand Formulary 2022b), diarrhoea and hypokalaemia. Recommended treatment for opioid-induced constipation (bpac^{nz} 2019).	• Docusate sodium and sennoside (Laxsol) combination product softens stool and stimulates peristalsis. Takes 6–12 hours to work.
Rectal preparation	**Examples and key information**
Stimulant suppository	• Glycerol: Insert into rectum touching mucus membrane; irritates bowel, stimulating peristalsis. Acts in 15 minutes to 1 hour (New Zealand Formulary 2022a). Prolonged use can cause atonic bowel. • Bisacodyl: Takes about 20 minutes to work.
Osmotic enema	• Sodium citrate (Micolette): Expect result in 10–15 minutes (may take longer). • Phosphate (Fleet): Generally reserved for surgical bowel preparation. Use with caution as directed by GP/NP because it can cause electrolyte disturbances.

Decision support

Bowel management to avoid constipation

Assess and manage constipation risk during routine review and following significant changes in routine

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Collect baseline bowel pattern (frequency, timing, straining, life-time habit, self-management)

Includes residential care history if routine review.
Use of laxative, bowel charting, episodes of acute constipation, toileting routines/habits
NB Pain or bleeding with defecation needs further investigation

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Assess stool consistency and volume (Bristol stool chart – 7-day detailed data collection)

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7-day food and fluid monitoring

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7-day physical activity record

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Identify constipation risks from medical history

Medical conditions increasing risk of constipation
- ☐ GI (haemorrhoids, bowel disease or prolapse)
- ☐ GU (catheter, vaginal prolapse)
- ☐ Neuro (Parkinson's, stroke, spinal cord injury, MS)
- ☐ Surgery GI or pelvic region
- ☐ COPD
- ☐ Hypothyroidism
- ☐ Functional limitation
- ☐ Cognitive impairment

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Identify constipation risks from medication

Medications increasing risk of constipation
- ☐ Diuretics (dehydration)
- ☐ Opioids (slow bowel transit)
- ☐ Anti-diarrhoeal
- ☐ Antihypertensives
- ☐ Anti-spasmodic
- ☐ Parkinson's medication
- ☐ Anticholinergics
- ☐ Iron supplements

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Consider impact of functional limitations (immobility) and cognitive impairment (poor recall) on constipation risk

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Consider need for digital rectal examination (history of haemorrhoids, bleeding or chronic constipation warrants an examination)

Any examination of kaumātua should follow principles of tapu and noa (see the *Guide for health professionals caring for kaumātua | Kupu arataki mō te manaaki kaumātua*)

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Develop care plan to address risk factors identified relating to diet, function and medication. Include referral to other health professionals

- ☐ Keep records of bowel function
- ☐ Regular physical activity (within limitations)
- ☐ Dietary fibre
- ☐ Fluid intake
- ☐ Discuss key risk medication with GP/NP
- ☐ Optimum management of chronic conditions
- ☐ Self-care activities (eg, supplementary foods or fluids, rituals or habits)

Source: Based on RNAO (2020)

COPD = chronic obstructive pulmonary disease
GI = gastrointestinal
GP = general practitioner
GU = genitourinary
MS = multiple sclerosis
NP = nurse practitioner

Responding to acute constipation

Constipation suspected:
No bowel movement in 1–3 days or bowel open, Bristol Stool Chart type 1 or 2

Consider in context of usual bowel habit

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Is this a new secondary cause (ie, associated with new bleeding or pain on defecation, abdominal pain, nausea or vomiting, delirium, weight loss or changed bowel habit)?

Y → Contact GP/NP for review

N ↓

Review history
Has anything changed (medically, functionally or mentally) in the resident's diet, fluid intake, medication regime that could cause constipation?

Complete abdominal examination
- ☐ Inspect abdomen for distention or bulges
- ☐ Auscultate bowel sounds
- ☐ Palpate (lightly and deeply)

Any time you find something abnormal, contact GP/NP before progressing with intervention

Auscultation
Normal bowel sounds: 5 to 35 clicks and gurgles in right lower quadrant

Abnormal bowel sounds (refer to GP/NP)
Fewer than 5 per minute in each quadrant
High-pitched tinkling sounds

Palpation
Press lightly over all areas of the abdomen, then deeply in the same places. A normal abdomen is described as soft and non-tender. Any tenderness or hard masses are unusual findings that you need to discuss with GP/NP

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Abnormal physical exam

Y → Contact GP/NP for review

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Fluid intake to reach 1.5 to 2 L in 24 hrs (provided there is no fluid restriction)
Start fluid chart
Add simple dietary stimulants
Give PRN laxative (osmotic agent or stimulant laxative) – can take 24 hours to work

Dietary stimulants include Kiwi Crush, apple and date mix, grapes, prunes, kiwifruit

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Bowel moved by day 4?

Y → Refer to managing constipation pathway, update care plan

N ↓

Abdominal examination, including digital rectal examination for faecal impaction
Follow facility protocol and discuss with nurse leader and/or GP/NP (eg, suppositories, multiple macrogol or enema)

Digital rectal examination (requires consent):
Lie resident on left side with knees flexed
Inspect anus for haemorrhoids/prolapse/tears
Lubricate gloved index finger and insert into anus. Feel for faecal mass. Inspect finger for mucus blood and faecal matter on withdrawal

Overflow diarrhoea is often faeces-coloured liquid. Explusion is often uncontrollable (incontinence). It is not accompanied by abdominal pain or fever

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Bowel moved by day 5?

N ↓

Physical examination as per day 4
Review history: Any new confusion, appetite loss, nausea or vomiting, overflow diarrhoea?

Y → **Rapid escalation to GP/NP**

N ↓

Discuss with GP/NP today and continue daily report to GP/NP until bowel opens

Bowel obstruction
Hard, swollen abdomen. Auscultation: high-pitched tinkling sounds, no clicks or gurgling sounds, no stool or gas expelled from bowel. Generally resident presents distressed and unwell, feels sick or vomits, has a painful abdomen and may be confused or disorientated

GP = general practitioner NP = nurse practitioner PRN = as needed ('pro re nata')

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