Managing constipation in older people in hospital

**In this article...**
- Why older people in hospital become constipated
- Prevention and management strategies
- The role of the health professional

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Constipation is a distressing disorder that is common among older patients in hospital. It is often underdiagnosed and undertreated, and can lead to increased morbidity and prolonged hospital stays. In most cases this common problem can be treated successfully if the correct management plan is adopted. This article reviews the prevention and management strategies available to address the issue.

Although it is not a direct result of the ageing process (Harari, 2004), constipation is the most prevalent bowel management problem in older adults (Mauk, 2005). It is common for older people to develop the condition during hospital admission (Kyle, 2008) and this may delay discharge (Lim et al, 2006). In addition to the distress caused to patients, this clearly has cost implications, which are likely to grow as the ageing population increases.

There are three types of constipation (Table 1). Causes of the condition are multifactorial and usually relate to:
- Slow transit of faeces through the colon;
- Evacuation difficulties (obstructive defecation) (Emmanuel, 2004).

Psychological (ie, rectocele, anal fissure, bowel stricture), physiological (ie, stress, depression) and environmental (ie, change in eating habits, immobility) factors can all play a role. Box 1 lists risk factors that are specific to older people.

Older people in hospital are at particular risk of constipation, especially after surgery, when changes in their diet, immobility and unfamiliar surroundings, and some analgesics such as opioid drugs, may lead to constipation. If the symptoms (Box 2) are left undetected, faecal impaction may develop, causing overflow faecal incontinence, distress for patients and increased morbidity.

**Defining constipation**

Constipation is a subjective experience and there is no universally accepted definition of it. Failure to assess and treat it effectively may be because health professionals and patients find it difficult to discuss bowel habits and may not share a common definition of their symptoms (Kyle, 2008).

There have been several attempts to provide an objective definition (National Institute for Health and Care Excellence, 2015), but it is difficult to accommodate all individual variations in bowel habits. Vargas (2009) suggests that, for most people, bowel movements normally occur between three times a day and three times a week.

Due to the lack of a definition there is little agreement on the prevalence of constipation and no recent data regarding its prevalence in patients who are in hospital. However, estimates of the prevalence of constipation in the general population in the UK range drastically, from 2% to 51% (Speed et al, 2010). This wide range reflects the problem of having no universal definition of the condition and highlights the importance of finding out how patients define their own symptoms (Norton, 2006).

**5 key points**

1. Constipation in hospitalised older people is poorly managed
2. There is no universally accepted definition of constipation
3. Failure to treat the condition can increase morbidity and prolong hospital stays
4. There is a lack of evidence to support assessment and management in the acute hospital setting
5. Constipation can be treated successfully with an individualised action plan
Effects of constipation

Constipation affects the overall wellbeing of older people. Symptom severity has been found to correlate negatively with perceived quality of life (Spinzi et al, 2009), and the condition has also been associated with anxiety, depression and poor health perception within this group (Norton and Chelvanayagam, 2004).

Assessment

Bowel function should be assessed when the patient is admitted to hospital; any concerns about constipation should be discussed and a plan of care devised to manage those concerns. If a patient complains of constipation:

» An accurate history of symptoms should be taken;
» The desired outcome of treatment should be considered.

This requires an individualised care pathway with appropriate treatment, and may pose significant challenges for nurses as the condition may not result from a single cause.

Norton (2005) has suggested that prescribing for constipation is largely based on habit and tradition, rather than evidence-based principles, because evidence is sparse. In older patients who report constipation, a careful physical, psychological, and bowel history should be taken. It should not automatically be assumed that the patient needs laxatives – inappropriate use of them may lead to further complications, such as cathartic damage to the colon in long-term use and decreased bowel function.

A digital rectal examination may be required to assess rectal loading or faecal impaction (Royal College of Nursing, 2012) but must only be undertaken by a health professional with the appropriate training.

Non-pharmacological management

Non-pharmacological approaches to managing constipation are often underused in acute hospital settings, where drug treatment is often administered with a view to “fixing the immediate problem” (Somes and Stephens Donatelli, 2013). However, simple non-pharmacological measures may aid defecation.

The environment should be assessed for lack of privacy, as constipation can occur if patients ignore or delay the decision to open their bowels (Rogers, 2012). This may occur if they are given a bedpan or commode behind a curtain, due to physical discomfort, or fear of odour and noise causing embarrassment. The problem can be overcome by:

» Wheeling older immobile patients to the toilet if possible;
» Ensuring they sit correctly on the toilet to raise their intra-abdominal pressure during defecation (Sikirov, 2003).

Proximity to the toilet is also important for older people with reduced mobility as they may feel embarrassed about asking for help to walk to the toilet.

Fluid intake

The role of increased fluid intake in managing constipation is debated. Chung et al (1999) found no significant change in stool output if fluid intake increased but their sample consisted of healthy volunteers with a mean age of 30. Müller-Lissner et al (2005) suggested that increasing fluid intake in older people may alleviate chronic constipation if there are signs of dehydration, but these findings cannot be generalised to acute symptoms in patients who are in hospital.

Physical activity

Müller-Lissner et al (2005) suggested a correlation between reduced activity and constipation in older people. Hsieh (2005) suggested that older patients in acute settings will experience impaired mobility or prolonged bedrest, contributing to the risk of constipation. The evidence base for this, however, is weak.

Diet

Eating a high-fibre diet is believed to play an important role in preventing and managing constipation. Denby (2006) recommended a daily intake of 18g of dietary fibre, as it is shown to improve bowel frequency and large bowel transit time. However, most studies on this intervention were undertaken more than 20 years ago and produced neither strong nor consistent findings on effectiveness of fibre intake in older people. A review by Kenny and Skelly (2001) found that fibre was not effective in older patients who were institutionalised.

Pharmacological management

If constipation is medication induced, lifestyle changes alone will be insufficient; alternative non-constipating medication should be considered (Spinzi et al, 2009).

There is no evidence-based guidance on the preferred order of using different types of laxatives (Hsieh, 2005), although hospitals often prescribe a combination of a stimulant laxative (senna) and an osmotic agent (lactulose). Osmotic agents should be used carefully as they require an increase in fluid intake (NICE, 2015); many older people self-impose a fluid restriction to control urinary frequency or are not encouraged or helped to take adequate

<table>
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<th>BOX1. RISKS FACTORS FOR CONSTIPATION IN OLDER PEOPLE</th>
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<tr>
<td>● Pre-existing disease (neurological and myopathic disorders, and degenerative diseases that affect mobility and functional status)</td>
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<td>● Polypharmacy</td>
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<td>● Difficulty accessing toilet facilities</td>
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<td>● Altered nutritional and fluid intake</td>
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Symptoms of constipation that present in older people:
- Confusion
- Overflow diarrhoea
- Nausea and loss of appetite
- Urinary retention
- Abdominal pain

Role of health professionals
Responsibility for bowel management is generally delegated to nursing staff, but joint responsibility between nursing and medical staff would be beneficial. A multi-disciplinary approach involving nurses, physiotherapists, dieticians and doctors would greatly improve treatment outcomes (Smith, 2010).

Health professionals should take a proactive approach to bowel management (NICE, 2007). Each patient’s risk of becoming constipated should be assessed on admission to establish a baseline that includes their history and presentation. Risk assessment tools have been described as the backbone of prevention and the heart of health promotion (Thompson, 2005). Unfortunately, such tools for constipation are sparse. The Norgine risk assessment tool for constipation appears comprehensive and could be used in the acute sector.

Challenges in hospital care
The literature provides evidence that, despite the high prevalence of constipation in older patients, the condition is often underdiagnosed and undertreated (Kyle, 2010; Grieve, 2006; Norton, 2006). There is a distinct lack of literature on the assessment of constipation and the multiple risk factors associated with the condition within an acute hospital setting. The lack of a universally accepted definition of the condition presents challenges in assessment and providing appropriate treatment, but constipation is a symptom and can be treated successfully if the correct management plan is adopted.

Conclusion
Nurses are in an ideal position to identify patients at risk of constipation and to assess for signs and symptoms. The promotion of good bowel habits is an important aspect of holistic management of patient care. A good knowledge and understanding of the risk factors for constipation aids its prevention.

References

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