Pharmacological Therapy Policy Practice Guidance Note
Bowel Care Management in Adults, Children and Young People Within Northumberland, Tyne and Wear NHS Foundation Trust – V03

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<td>7</td>
<td>Clozapine induced constipation – Key card</td>
<td>1</td>
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1. Introduction

1.1 Normal bowel function includes the need for regular defecation without complications such as constipation or diarrhoea. There is no accepted level of normality although bowel movements occurring less than three times a week is one criteria for constipation (Rome criteria).

1.2 There is no accepted definition for constipation. The term is most commonly used to mean defecation that is unsatisfactory because of infrequent stools, difficult stool passage or seemingly incomplete defecation.

1.3 Constipation can be functional without a known cause (also known as idiopathic) or secondary caused by a drug or medical condition (also known as organic).

1.4 Severity can vary from slight, causing no disruption to life, to severe, affecting physical, psychological and social well-being.

1.5 Constipation may be associated with a variety of symptoms as well as difficulty in evacuating rectal contents.

2. Aim of the Practice Guidance Note

2.1 This policy has been developed to standardise bowel management throughout Northumberland, Tyne and Wear NHS Foundation Trust (the Trust/NTW) inpatient population. This encompasses children and young people as well as adults of all ages.

2.2 Ensure that healthy lifestyle measures are adopted to promote bowel management.

2.3 Identify key factors in assessment of constipation.

2.4 Identify key factors in assessment of diarrhoea.

2.5 Ensure that patients receive evidence based care in the management of constipation and diarrhoea.

2.6 Clarify the role and use of Digital Rectal Examination (DRE).

2.7 Standardise appropriate prescribing of laxatives within the trust.

2.8 Standardise bowel management by developing a care pathway. See Appendix 1.
3. **Symptoms of Constipation**

3.1 **Table 1** shows the symptoms associated with constipation.

<table>
<thead>
<tr>
<th>Table 1 – Symptoms associated with constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defecation</strong></td>
</tr>
<tr>
<td>Infrequent stools</td>
</tr>
<tr>
<td>No urge</td>
</tr>
<tr>
<td>Stools difficult to pass</td>
</tr>
<tr>
<td>Ineffective straining</td>
</tr>
<tr>
<td>Sense of incomplete evacuation</td>
</tr>
<tr>
<td>Anal or perianal pain</td>
</tr>
<tr>
<td>Soiling of clothes</td>
</tr>
</tbody>
</table>

4. **Causes of Constipation**

4.1 Conditions which may cause constipation

4.2 **Table 2** shows conditions which may cause or contribute towards constipation.

<table>
<thead>
<tr>
<th>Table 2 – Conditions which may cause or contribute to constipation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anorexia</strong></td>
</tr>
<tr>
<td>Admission to hospital for any cause</td>
</tr>
<tr>
<td>Bowel obstruction</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Clinical depression</td>
</tr>
<tr>
<td>Dehydration</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Diverticular disease</td>
</tr>
<tr>
<td>Haemorrhoids, anal fissures, polyps, Rectocele, anal or rectal pathology</td>
</tr>
<tr>
<td>History of constipation</td>
</tr>
<tr>
<td>Hypercalcaemia</td>
</tr>
<tr>
<td>Hypothyroidism</td>
</tr>
</tbody>
</table>
4.3 Medications which may cause constipation

4.4 **Table 3** shows some medications which are known to cause or contribute to constipation

<table>
<thead>
<tr>
<th>Class of Medication</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Opioid analgesics - including compound products</td>
<td>Morphine, codeine, dihydrocodeine co-codamol, co-dydramol</td>
</tr>
<tr>
<td>2. The following drugs with antimuscarinic (anticholinergic) effects</td>
<td>Tricyclic/ SSRI/SNRI antidepressants, Amitriptyline, fluoxetine, mirtazapine</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Clozapine, risperidone, chlorpromazine,</td>
</tr>
<tr>
<td>Anti-parkinsonian</td>
<td>Orphenadrine, benztropine, trihexyphenidyl, procyclidine</td>
</tr>
<tr>
<td>Antihistamines – especially older sedating antihistamines</td>
<td>Chlorphenamine, promethazine, cyclizine</td>
</tr>
<tr>
<td>Antispasmodics</td>
<td>Propantheline, hyoscine.</td>
</tr>
<tr>
<td>3. Calcium salts</td>
<td>Contained in some antacids &amp; phosphate binders</td>
</tr>
<tr>
<td>4. Diuretics</td>
<td>Furosemide, bendroflumethiazide</td>
</tr>
<tr>
<td>5. Aluminium salts</td>
<td>in many antacids</td>
</tr>
<tr>
<td>6. Iron salts</td>
<td>Ferrous sulphate</td>
</tr>
<tr>
<td>7. Calcium channel blockers</td>
<td>Verapamil</td>
</tr>
<tr>
<td>8. NSAIDs (n.b. more commonly cause diarrhoea).</td>
<td>Ibuprofen, diclofenac</td>
</tr>
<tr>
<td>9. 5HT₃ antagonists</td>
<td>Ondansetron</td>
</tr>
<tr>
<td>10. Selected antiepileptics</td>
<td>Carbamazepine, gabapentin, oxcarbazepine, pregabalin, phenytoin</td>
</tr>
<tr>
<td>11. Polypharmacy – more than 5 drugs from above</td>
<td></td>
</tr>
</tbody>
</table>

4.4 Clozapine and Clostridium Difficile Infection

- The constipating effects of clozapine may mask signs and symptoms of Clostridium difficile (*C. difficile*) infection

- **C. difficile** is the major cause of antibiotic-associated diarrhoea and colitis, an infection of the intestines
• It is part of the Clostridium family of bacteria, which also includes the bacteria that cause tetanus, botulism, and gas gangrene. It is an anaerobic bacterium (i.e. it does not grow in the presence of oxygen) and produces spores that can survive for a long time in the environment

• **C. difficile** can be found living in the large intestine of a small proportion (less than 5%) of the healthy adult population

• It is also common in the intestine of babies and infants. It is normally kept in check by the ‘good’ bacterial population of the intestine. But when these good bacteria have been killed off by antibiotics, it is able to multiply in the intestine and produce two toxins that damage the cells lining the intestine. The result is diarrhoea, this can range from a mild disturbance to a very severe illness with ulceration and bleeding from the colon (colitis) and, at worst, perforation of the intestine leading to peritonitis. It can be fatal

• Most of those affected are elderly patients with serious underlying illnesses. Most infections occur in hospitals (including community hospitals), nursing homes etc, but it can also occur in primary care settings

• Patients who are most at risk of infection with **C. difficile** are those who have recently been treated with antibiotics. Those antibiotics most frequently associated with **C. difficile** include clindamycin, penicillins and cephalosporins but virtually any antibiotic may be implicated

• Patients taking antipsychotics such as clozapine may remain asymptomatic due to the constipating effects of their medication therefore routine questioning in clinic or with patients on the ward should establish the following:

4.4.1 Has the patient been recently prescribed an antibiotic course?

4.4.2 Has the patient experienced any bowel problems?
  - constipation
  - loose, watery stools

4.4.3 Has the patient been experiencing?
  - blood in the stools
  - any abdominal cramps
  - fever
  - The presence of symptoms described in 4.4.3 following an antibiotic course would require an urgent medical referral for follow up
  - For more information see the Trust’s NTW(C)23, Infection, prevention and control policy, practice guidance note, IPC-PGN-22 - Prevention and control of clostridium difficile
5. **Patient Assessment - Adults all ages**

5.1 The key to successful management of constipation lies in the assessment and identification of the underlying cause. There are many contributory factors associated with constipation and individuals often experience more than one underlying problem. Assessment should be made through observation and questioning as part of physical health screening.

5.2 Assessment should take the following into consideration:

<table>
<thead>
<tr>
<th>Bowel function</th>
<th>Underlying disease (Table 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>Medication – prescribed and any bought over the counter (Table 3)</td>
</tr>
<tr>
<td>Ability to chew/swallow</td>
<td>Mobility (including gait and posture)</td>
</tr>
<tr>
<td>Oral care</td>
<td>Fluid intake</td>
</tr>
<tr>
<td>Mechanical obstruction</td>
<td>Stroke</td>
</tr>
<tr>
<td>Environment</td>
<td>Pregnancy</td>
</tr>
</tbody>
</table>

5.3 The Bristol Stool Chart should be used to allow nursing staff and patients the opportunity to identify stool specimens and stool frequency. (Appendix 2)

5.3.1 The Norgine Risk Assessment Tool for Constipation allows nursing staff to identify patients at high risk of constipation and give advice on management. (Appendix 3 and 4)

5.4 **Functional Assessment**

5.4.1 Compromised mobility increases the risk of faecal incontinence resulting from severe constipation, especially in patients who depend upon others to assist them with their toileting needs.

5.4.2 Aspects of a functional assessment should include:

- Mental function
- Mobility
- Dexterity
- Environment
- Eyesight
- Height of bed and chair
- Flooring
- Type of footwear

5.5 **Physical Assessment**

5.5.1 A general physical examination should be undertaken, observing posture, gait and any lower back problems.
5.5.2 An abdominal examination may be performed by staff that have been assessed as competent to identify distension, pain and tenderness.

5.5.3 A digital rectal examination may be required to assess rectal loading/faecal impaction and consistency of the faecal material. This may be performed by appropriately trained nursing or medical staff as part of the assessment of constipation where clinically indicated. (See Section 14)

6. Patient Assessment – Children and Young People

6.1 The frequency at which children pass stools varies with age. The normal range is between three stools per day and three stools per week NICE establishes constipation in children aged one year and over when 2 or more of the symptoms listed in Table 4 below are present. See the National Institute for Health and Care Excellence (NICE), clinical guideline; CG 99 – Constipation in Children and Young People.

Table 4 Key Components of history taking to diagnose constipation in children/young people older than 1 year

<table>
<thead>
<tr>
<th>Key Components</th>
<th>Potential Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool patterns</td>
<td>&lt; 3 complete stools per week (type 3 or 4 Bristol Stool Form Scale) | Overflow soiling | Rabbit droppings (type 1 Bristol Stool Form Scale) | Large infrequent stools that can block the toilet</td>
</tr>
<tr>
<td>Symptoms associated with defecation</td>
<td>Poor appetite that improves with passage of large stool | Waxing and waning of abdominal pain with stool passage | Evidence of retentive posturing: typical straight legged, tiptoe, back arching posture | Straining | Anal pain</td>
</tr>
<tr>
<td>History</td>
<td>Previous episode (s) of constipation | Previous or current anal fissure | Painful bowel movements and bleeding associated with hard stools</td>
</tr>
</tbody>
</table>
6.2 Refer to medical staff who will take a history and follow up with a physical examination where clinically indicated.

6.3 Children must consume a diet containing sufficient fluid and fibre to promote the movement of faeces through the colon.

6.4 They must respond appropriately to bodily clues for defecation and learn where it is appropriate to open their bowels.

6.5 The process of learning socially acceptable toileting can be compromised if the learning experience is painful due to constipation.

6.6 Constipation often develops when the child associates pain with defecation and begins to withhold stools. The rectum gradually enlarges to accommodate the retained stool and the normal urge to defecate is reduced.

6.7 Passing infrequent, large, hard stools reinforces the association of pain with defecation, causing worsening stool retention.

6.8 Lack of fibre causes low faecal bulk and results in reduced peristalsis.

6.9 Inadequate fluid intake or excessive fluid loss e.g. due to vomiting, diarrhoea or febrile illness may cause hardening of the stool and constipation.

6.10 Assessment in children and young people should take the following into consideration:

<table>
<thead>
<tr>
<th>Duration of the problem</th>
<th>Frequency/consistency/ size of stools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of blood/mucous</td>
<td>Any associated soiling</td>
</tr>
<tr>
<td>Any urinary symptoms</td>
<td>Effect on appetite</td>
</tr>
<tr>
<td>Abdominal symptoms (pain)</td>
<td>Nausea and vomiting</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Previous management</td>
</tr>
<tr>
<td>Any investigations</td>
<td>Birth history</td>
</tr>
<tr>
<td>Assessment of diet + fluid intake</td>
<td>Amount of exercise undertaken</td>
</tr>
<tr>
<td>Other medical problems</td>
<td>Family history</td>
</tr>
<tr>
<td>Behavioural issues (including toilet training)</td>
<td>Current medication</td>
</tr>
<tr>
<td></td>
<td>(including those bought over the</td>
</tr>
<tr>
<td></td>
<td>counter and herbal remedies)</td>
</tr>
</tbody>
</table>

6.11 The majority of children with constipation have no underlying pathology and do not need in depth examination and investigation.
6.12 The following examination may be undertaken by an appropriately trained medical practitioner if clinically necessary:

- Assess sacral nerve roots by testing knee/ankle reflexes
- Abdomen palpitation to check for faecal mass
- Inspection of anal area

7. **Symptoms requiring medical referral (Adults)** see section 10.8 for the equivalent information relating to children

7.1 If any of the following symptoms present the relevant medical practitioner should be contacted:

7.2 Be alert for any 'red flag' symptoms that might indicate a serious underlying condition. Is there:

- Persistent unexplained change in bowel habit?
- Palpable mass in the lower right abdomen or the pelvis?
- Persistent rectal bleeding without anal symptoms?
- Narrowing of stool calibre?
- Family history of colon cancer, or inflammatory bowel disease?
- Unexplained weight loss, iron deficiency anaemia, fever, or nocturnal symptoms?
- Severe, persistent constipation that is unresponsive to treatment?

7.3 When clinically appropriate a stool sample may be requested.

8. **Management of Constipation**

8.1 The aims of management include:

- Establishing a normal frequency of defecation for the individual
- Establishing a regular comfortable defecation using the least number of drugs (ideally none) for the least amount of time
- Preventing laxative dependence
- Relieving discomfort
- Promoting a healthy lifestyle
8.2 For short duration constipation:

- Adjust any constipating medication
- Advise the person about increasing dietary fibre, drinking an adequate fluid intake, and exercise.
- If no response consider laxative treatment

8.3 For chronic constipation:

- First relieve faecal impaction/loading if present
- Advise about diet, fluid and exercise as above
- Consider laxative treatment

8.4 If Medication is required follow the flowchart – The Newcastle upon Tyne Hospitals NHS Foundation Trust – Treatment of Constipation - adults– see Appendix 5 for the following conditions.

- Faecal impaction
- Opioid induced
- Acute
- Chronic
- Palliative care

8.5 For people with long-term mobility problems, neurological illness, a combined treatment strategy will be required.

8.6 Patients who rely on opiates for pain relief a strategy should be developed combining medication and healthy life style where possible.

8.7 Colour and consistency of faecal matter can provide important information that can assist in diagnosis and monitoring of a patients’ condition. See Appendix 2 Bristol Stools Chart for guidance

8.8 Any persistent alteration in a patient’s bowel habits must be investigated as this may indicate a serious disorder such as carcinoma of the bowel or inflammatory bowel disease.
9 Managing Constipation in Adults - Lifestyle Management

9.1 Improving diet, fluid intake and toileting routine along with increased activity play a major part in the prevention and management of constipation. Lifestyle guidance as below must be implemented as a first line approach to management. Improvements with this approach may be seen in a few days but may take as long as 8 weeks.

9.2 For further information visit the appropriate reference source.

  www.waterforhealth.org.uk

10. Management of Constipation in Children and Young People – See NICE CG99 for further information
http://www.nice.org.uk/guidance/cg99

10.1 Causes of Constipation:

10.2 Idiopathic (functional) constipation is defined as the subjective complaint of passing abnormally delayed or infrequent dry, hardened faeces (stools) often accompanied by straining and/or pain. It may also be associated with soiling, defined as involuntary passage of fluid or semi-solid stool into clothing, usually as a result of overflow from a faecally loaded bowel. Constipation is termed idiopathic if it cannot be explained by a known cause (anatomical, physiological, radiological or histological abnormalities). The exact aetiology is not fully understood, but it is generally accepted that a combination of factors may contribute to the condition. (NICE - CG 99).

10.3 A number of medical disorders can cause chronic constipation. True constipation in infants and children that has been present since birth may be Hirschsprung disease.

10.3.1 This is a congenital condition that is uncommon; it is a condition in which there is no ganglion cells (a type of nerve cell) located in a segment of the colon.

10.3.2 As a result, the colon cannot receive directions from the brain to function properly.

10.3.3 Most infants with Hirschsprung disease generally will have symptoms within the first few weeks of life. They may be underweight or small for their age. They may vomit and pass small, ribbon-like stools.
10.3.4 Hirschsprung disease is generally more common in boys and in babies. An empty contracted anal canal in a constipated child may suggest Hirschsprung disease, if Hirschsprung disease is suspected you need to refer to a paediatrician.

10.4 The most common cause of constipation in a child older than 18 months is the avoidance of going to the toilet for various reasons.

10.4.1 Children with disorders of the nervous system such as cerebral palsy, learning disability, or spinal cord problems have a high rate of constipation because they have prolonged time in one position, abnormal colon movement, and lack coordination in moving their bowels.

10.5 Other causes of constipation include depression, coercive toilet training, attention deficit disorders and sexual abuse.

10.6 **Management Aims**

10.6.1 Based on clinical experience, a thorough physical examination is recommended as part of a complete evaluation of a child with constipation.

10.6.2 It is vital that early identification of symptoms, diagnosis, effective treatment and consistent advice and support are offered to children who suffer from constipation and their families. It is also important to differentiate between children with functional constipation (the vast majority) and those with organic disease, so that they all receive appropriate diagnosis and management.

10.6.3 The aim when treating a child with constipation is;

- Establishing a normal frequency of defecation for the individual.
- Establishing a regular comfortable defecation using the least number of drugs (ideally none) for the least amount of time.
- Preventing laxative dependence
- Relieving discomfort
- Promoting a healthy lifestyle

10.6.4 Infants and Children with constipation are treated differently than adults because patterns of bowel movements change from the time they are born until they are aged 3 or 4 years. The majority of children with constipation do not have a medical disease or disorder causing the constipation.

10.6.5 Encourage children to exercise more and have an adequate fluid intake.
10.6.6 Increased dietary fibre causes a softer, bulkier stool to move through the gastrointestinal tract more quickly. To increase fibre in children’s diets, more emphasis should be placed on the consumption of high fibre breakfast cereals, breads, and crackers, as well as an increased intake of fresh fruits and vegetables. The recommendation of dietary fibre for children older than 2 years of age:

- grams of fibre/day = age in years + 5

10.6.7 Water intake should be increased when dietary fibre intake increases as this produces a bulkier and softer stool.

10.6.8 Consider laxative treatment if;

- Red flags have been excluded
- Idiopathic constipation has been diagnosed
- Check and treat faecal impaction first
- Then use maintenance laxatives

10.7 Symptoms requiring medical referral

10.7.1 Refer for medical assessment when:

- An underlying cause is suspected.
- There are 'red or amber flag' symptoms present, both of which require referral to a specialist. The amber flag patients can receive treatment while awaiting the referral

<table>
<thead>
<tr>
<th>Red Flags</th>
<th>Amber Flags</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms from birth</td>
<td>Faltering growth</td>
</tr>
<tr>
<td>Delay in passing meconium for more than 48 hours</td>
<td>Developmental delay</td>
</tr>
<tr>
<td>Abdominal distension with vomiting</td>
<td>Introduction of cow’s milk as a trigger</td>
</tr>
<tr>
<td>Ribbon stool pattern</td>
<td>Maltreatment</td>
</tr>
<tr>
<td>Leg weakness or motor delay</td>
<td></td>
</tr>
<tr>
<td>Abnormal anal region i.e.fistulae</td>
<td></td>
</tr>
<tr>
<td>Abnormal gluteal region i.e.asymmetry</td>
<td></td>
</tr>
</tbody>
</table>

- Treatment is unsuccessful
- Management is complex (and requires more than the advice, support, and prescription of laxatives that can be provided in primary care because there are major psychological causes or consequences).
10.8 Nurses will not carry out a Digital Rectal Examination on children, a referral must be made to a Consultant Paediatrician who will assess the child and he/she will carry out this procedure if they decide it is appropriate.

10.9 Establishing a toilet-sitting schedule (20 minutes after meals 2 to 3 times a day for 10 to 15 minutes) to take advantage of the gastro colic reflex will help. When using the toilet, the child needs privacy and unhurried time. It is recommended to use a timer to prevent the child from constantly asking when he can get up.

10.10 Proper positioning on the toilet will facilitate defecation. When sitting on the toilet, the child needs to be encouraged to press the feet flat on the floor, or if the child is small, to use a bench or foot stool. See Figure 1. (The Correct Position for Opening Bowels)

10.10.1 Positive reinforcement for sitting and stool results, keeping a calendar and recording stool passage will give the child evidence of success. Initial reinforcement should be carried out frequently.

11 Pharmacological Treatment of Constipation

11.1 Laxatives

11.1.1 In general, there is much uncertainty over what constitutes effective management of constipation and laxatives may not be appropriate in all constipated patients. It has been suggested that in mobile people (including the elderly), a change in lifestyle involving changes in diet, increasing fluid intake and increasing physical activity may be sufficient.

11.1.2 Although laxatives are not always necessary, they may be needed in the short term to provide rapid initial relief of symptoms (MeReC Bulletin, 2011).

11.1.3 Laxatives alter the normal functioning of the alimentary tract and can be grouped into four types according to their action:

- Bulking agents
- Stool softeners
- Osmotic agents
- Stimulants

11.1.4 NB. This section refers to some of the laxatives available in the four group types. Prescribing will be guided by the North of Tyne Area Prescribing Committee Formulary.

11.1.5 All medicines should be used only according to their licensed indications.
11.2 **Bulking Agents**

11.2.1 Bulk laxatives are of particular value for people complaining of small, hard stools but should only be considered if fibre cannot be increased in the diet.

11.2.2 **These agents supplement dietary fibre intake to increase the weight and water absorbency of the stool. They act by retaining fluid within the stool and increase faecal mass leading to stimulation of peristalsis.** These agents need an increased fluid intake in order to work and should be taken with at least one glass of water. They take 2-3 days to exert their effect and so are not suitable for acute relief.

11.2.3 Adequate fluid intake must be maintained to avoid intestinal obstruction and therefore they are contra-indicated in patients with faecal impaction or existing bowel obstruction. E.g. Ispaghula Husk 3.5g sachets

11.2.4 **NB:** May cause transient bloating and flatulence.

11.3 **Stimulant laxatives**

11.3.1 Stimulant laxatives increase intestinal motility with a laxative effect seen in 6-12 hours. They can cause abdominal cramping and should be avoided in cases of intestinal obstruction. A stool softener may be used in combination with this group of laxatives. Prolonged use of stimulant laxatives can precipitate the onset of an atonic, non-functioning colon and hypokalaemia. However, long-term use may be justified for those people taking long-term opiates. E.g. Senna first line alternatives: docusate sodium (also acts as a faecal softener), bisacodyl, glycerol

11.3.2 Preparations containing Danthron (Co-Danthramer, Co-Danthrusate) are not indicated for general use and should only be used for analgesic-induced constipation in palliative care for patients of all ages.

11.4 **Faecal Softeners**

11.4.1 These act by lowering the surface tension of faeces which allows water to penetrate and soften the stool. Softening agents take 24-48 hours to work. Faecal softeners are useful when the patient suffers from haemorrhoids or anal fissure. E.g. docusate sodium, arachis oil retention enema

11.4.2 Arachis oil is contra-indicated in patients with a known nut allergy.
11.5 Osmotic agents

11.5.1 These act by retaining fluid in the bowel by osmosis or by changing the pattern of water distribution in the faeces. They can cause bloating, flatulence and cramping and must be taken regularly for up to three days before an effect is seen. Therefore they are unsuitable for rapid relief of constipation. Lactulose is a synthetic disaccharide which exerts an osmotic effect in the small bowel.

11.5.2 Distension in the small bowel induces propulsion which in turn reduces transit time.

11.5.3 Macrogol is a preparation containing polyethylene glycol and various electrolytes and is recommended as first line osmotic laxative in preference to lactulose.

11.5.4 Magnesium Salts produce rapid bowel evacuation and when given in large doses cause defecation in one to two hours. They should normally be reserved for bowel clearance prior to surgery, e.g. Lactulose / Macrogol / Magnesium Salts

11.6 Bowel Cleansing Solutions

11.6.1 Death and harm from electrolyte abnormalities, dehydration and serious gastro-intestinal problems have been reported following the inappropriate use of oral bowel cleansing solutions (Picolax®, Citrafleet®, Fleet Phospho-Soda®, Klean Prep®, Moviprep®) prior to surgery and/or investigative procedures.

11.6.2 Frail and debilitated elderly patients, children and those with contraindications are particularly at risk from these treatments. The National Patient Safety Agency (NPSA) and the Medicines and Healthcare products Regulatory Agency (MHRA) have received reports of patient harm with use of these products in the past indicating electrolyte imbalance or dehydration due to inappropriate fluid intake, or use of the products where there is a clinical contraindication.

11.6.3 These products will be prescribed and supplied by the clinician requesting the procedure who will ensure clinical appropriateness for the individual patient. They will only be supplied by the Trust’s Pharmacy when submitted with a non-formulary request.

11.7 Suppositories

11.7.1 When oral laxatives have not produced a bowel movement or when rapid relief from rectal loading is required, a suppository may be appropriate. A suppository is a solid or semi-solid pellet introduced into the rectum containing medication.
11.7.2 **Lubricant** suppositories e.g. glycerin, should be inserted directly into the faeces and allowed to dissolve to enable softening of the faecal mass. Licensed for occasional use only

11.7.3 **Stimulant** suppositories e.g. bisacodyl, must come into contact with the mucus membrane of the rectum if they are to be effective and should not therefore be inserted into a faecal mass.

11.7.4 **Indications for use**
- To relieve acute constipation or to empty the bowel when other treatments for constipation have failed
- To empty the bowel before surgery
- To introduce prescribed medication into the system
- To soothe and treat haemorrhoids or anal pruritis
- As part of a bowel management programme with someone who has a neurogenic bowel

11.7.5 **Contraindications for use**
- Colonic obstruction
- Paralytic ileus

11.8 **Enemas – Licensed for occasional use only**

11.8.1 When oral laxatives or suppositories have not produced a bowel movement or when rapid relief from rectal loading is required, an enema may be appropriate. An enema is the introduction of fluid into the rectum or lower colon for the purpose of producing a bowel action or instilling medication. There are two types of enema: *retention enemas* and *evacuant enemas*.

11.8.2 A **retention enema** is a solution introduced into the rectum or lower colon with the intention of being retained for a specified period of time. Arachis oil enema comes under this group and is useful for softening and lubricating impacted faeces. Medicated retention enemas e.g. Prednisolone enemas are indicated in inflammatory bowel conditions.

11.8.3 An **evacuant enema** is a solution introduced into the rectum or lower colon with the intention of its being expelled along with faecal matter. Phosphate enemas and sodium citrate micro-enemas come under this group.

- Phosphate enemas should be used with caution as they can cause mucosal damage and trauma
11.8.4 **Indications for use**

- To introduce prescribed medication into the system
- Severe constipation or impaction of faeces
- To clean lower bowel before surgery
- Neurogenic bowel

11.8.5 **Contraindications for use**

- Colonic obstruction
- Paralytic ileus
- Where large amounts of fluid into the colon may cause perforation or haemorrhage
- Following gastrointestinal or gynaecological surgery where suture lines could be ruptured (unless medical consent has been given)
- In patients with a known cardiac condition where intervention could cause possible collapse

12 **Pharmacological Treatment of Constipation in Adults**

12.1 Pharmacological treatment is not always necessary but maybe appropriate when:

- No response to adequate lifestyle and dietary advice (e.g. after 1 month)
- Faecal impaction
- Post-surgery/pregnancy
- Elderly with a poor diet
- Drug induced
- Medical condition where bowel strain is undesirable (e.g. coronary heart disease)
- In preparation for an operation

12.2 Pharmacological treatment must be in line with the recommendations of The Newcastle Upon Tyne Hospitals NHS Foundation Trust – Treatment of Constipation in Adults. (Appendix 5)

13 **Pharmacological Treatment of Constipation in Children and Young People**

13.1 Will be prescribed for the individual by authorised Trust practitioners with advice from paediatricians where necessary e.g. for complex cases in accordance with Nice Guidance see Appendix 6.
14 Digital Rectal Examination and Administration of Suppositories and Enemas

14.1 Digital rectal examination (DRE) is an invasive procedure and should only be performed if deemed clinically necessary following individual patient assessment.

14.2 DRE should be performed by a nurse who can demonstrate clinical and professional competence to the level determined by the NMC Code of Professional Conduct.

14.3 The Royal College of Nursing (RCN) has produced clear guidelines for nurses working with adults in their documentation, ‘Procedure for the Digital Removal of Faeces Guidelines 2012 version 3’. For a limited number of children and young people, particularly those with spinal injuries, these procedures will form an important component of their bowel management routine, however, nurses working with children should refer to RCN guidance for children document, RCN (2003, Revised 2005).

14.4 With advances in oral, rectal and surgical treatments in recent years, the need to use DRE and manual removal of faeces has reduced. But for certain patients, these procedures are still part of their bowel management routine – and so there are still many nurses caring for these patients who need to be sure they are acting according to best practice, and within the right ethical and legal framework.

14.5 Manual removal of faeces (manual evacuation) is an established technique for the management of bowel care in some spinal patients. Such a procedure should be regarded as a last resort and should only be performed following discussion with the patient’s medical practitioner.

14.6 In order to reduce variations in practice and the risk of errors the Trust is providing a standardised approach for the procedure of digital rectal examination (DRE).

14.7 Manual evacuation should be avoided if at all possible since it is a distressing, often painful and potentially dangerous procedure for the patient. It should only be performed if all other methods of relieving constipation have failed. The patient should be clinically assessed by a medical practitioner and an individual treatment strategy developed accordingly.

14.8 It is not envisaged that this will be a frequent or routine procedure. Nurses involved will be required to train with continence advisors via primary care services.
Digital rectal examination is recognised as skilled procedure that requires appropriate training and competence. Evidence based training that has been approved by the nursing profession will;

- Inform nurses of the professional and legal aspects of DRE.
- Enable nurse to understand issues of consent for the procedure and rectal administration of medicines.
- Enable nurses to decide which group of patients is suitable for this type of bowel management.
- Enable nurses to be aware of the circumstances when extra care is required.
- Inform nurses how to identify stools by using the Bristol Stool Chart, (see Appendix 2).

DRE can be used as part of a nursing assessment to establish the presence of stool in the rectum prior to administering rectal preparations such as suppositories.

DRE should not be considered the primary investigation in the assessment and treatment of constipation.

DRE in children should only be performed as part of a medically prescribed treatment plan.

Cultural and religious beliefs need to be considered before undertaking DRE.

**Circumstances when extra care is required:**

- Particular caution is needed when performing these procedures with patients who have the following diseases and conditions:
  - Active inflammation of the bowel, including Crohn's disease, ulcerative colitis and diverticulitis.
  - Recent radiotherapy to the pelvic area
  - Rectal/anal pain
  - Rectal surgery/trauma to the anal/rectal area
  - Tissue fragility due to age, radiation, loss of muscle tone in neurological diseases or malnourishment
  - Obvious rectal bleeding
  - If patient has a known history of abuse
  - In spinal injured patients because of autonomic dysreflexia
  - If patient has a known history of allergies
14.15 **When to refer to Medical Staff:**
- Accompanying abdominal pain or vomiting
- Blood and/or slime in the stool
- Change in normal bowel habit
- Diarrhoea alternates with constipation
- If any abnormality is felt upon digital rectal examination

14.16 **Exclusion Criteria**

14.16.1 Nurses should not undertake DRE when:
- There is a lack of consent from the patient – verbal, written or implied, although the law is specific about issues of consent in an emergency situation and if treatment is required to safeguard the life or health of an individual it is not a legal requirement to obtain the patients consent. Specific instructions have been given that these procedures should not take place.
- The patient has undergone recent rectal/anal surgery or trauma.
- Presence of abnormalities of the perineal and surrounding area.
- The patient gains sexual satisfaction from these procedures and the nurses performing them finds this embarrassing. This should be discussed within the multidisciplinary team.
- Management should be documented in a care plan and a chaperone may be used.
- Acute spinal cord injury.
- The nurse has not undertaken training regarding DRE or bowel management.
- Where all other bowel management techniques have not previously been tried.

15 **Autonomic Dysreflexia in Spinal Cord Injury Patients:**

15.1 Autonomic dysreflexia (AD) is a condition that develops after spinal cord injury in which potential life threatening episodic hypertension is triggered by stimulation of the sensory nerves below the site of the injury. AD can occur in patients with an injury usually above T-6.

16 **Management of Diarrhoea**

16.1 The British Society of Gastroenterology defines diarrhoea as 'the abnormal passage of loose or liquid stools more than 3 times daily and/or a volume of stool greater than 200 g/day'
16.2 Diarrhoea that comes on suddenly and lasts for longer than a couple of days is usually referred to as acute diarrhoea. Most people recover from this in a few days without treatment. However, this type of diarrhoea may be a symptom of the occurrence of an infection such as; gastroenteritis, norovirus, salmonella, campylobacter, clostridium difficile, E coli, typhoid or hepatitis. Further advice can be obtained by contacting the Infection Prevention Control Matron.

16.3 The frequency of diarrhoea should also be monitored and recorded. The Bristol stool chart should be used to describe and monitor the type of stool passed. The Doctor should be informed if a patient is experiencing diarrhoea.

16.4 Chronic or persistent diarrhoea generally lasts longer and may have more complex origins. Causes can be:

- inflammatory bowel disease
- neoplasms
- diverticulitis

16.4.1 In these circumstances the patient will need to be seen by a doctor for assessment.

16.5 Once the cause of diarrhoea has been established, management should focus on resolving the cause of the diarrhoea and providing physical and psychological support for the patient.

16.6 The prevention and correction of dehydration is the first step in managing an episode of diarrhoea:

- encouraging the patient to drink fluids to suit individual taste
- adding ice to drinks
- sucking ice cubes or ice lollies
- Electrolyte replacement therapy

16.7 Faecal movement, resembling diarrhoea, can occur as a result of colonic obstruction and therefore this should be ruled out when the patient presents with diarrhoea.

16.8 In residential units or hospital wards in particular, staff must be aware of the risks of cross infection and should consider episodes of diarrhoea as potentially infectious until proved otherwise. See Trust policy NTW(C) 23, Infection, Prevention and Control Policy and practice guidance notes.

16.9 Staff should be particularly attentive to the risk of antibiotic associated diarrhoea including C.difficile infection. See IPC-PGN-22 Prevention and control of Clostridium difficile.
17 References


- Zejdlik, C (1992) Management of Spinal Cord Injury. Boston, Jones & Bartlett Bladder and Bowel Fact sheets can be found on [www.spinal.co.uk](http://www.spinal.co.uk)