Cutting Through the Foggy Myths Using Best Practice Guidelines in Long Term Care

BP Blogger

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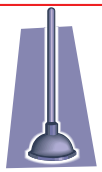
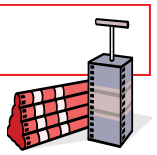
Myth Busting: The Bowel Issue

Myth 1: Constipation is not serious



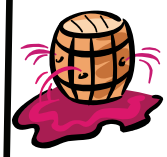
The most common bowel management problem in older people is constipation but it's not a problem that results from aging. Older people can have normal bowel function but many are exposed to medical conditions such as , diabetes, depression, dementia, and stroke; and medications, low calorie/fibre intake, immobility and ignoring the urge to defecate that increases the risk for constipation. Constipation is a common problem in LTC with up to 50% of residents experiencing this condition and 58-75% receiving at least one type of laxative. Half of these residents took a daily laxative, yet only 62% of them met the Rome II criteria for constipation. Laxative use was more common in those who were immobile, had Parkinson's disease or diabetes mellitus, or took iron supplements, calcium channel antagonists, or antidepressants. Chronic constipation not only affects older persons' quality of life but sometimes it can lead to serious complications such as fecal impaction, bowel obstruction, bowel perforation/ ulcers, megacolon, volvulus, incontinence, rectal prolapse, hemorrhoids, laxative abuse and cardiac and/or cerebrovascular dysfunction.

What is constipation?



The Rome II criteria (2004), global consensus of gastroenterological experts, define constipation as the presence of 2 or more symptoms during the past 12 months:

1. straining for more than 25% of BMs
2. hardened stools with more than 25% of BMs
3. sensation of incomplete evacuation of stool more than 25% of bowel movements
4. sensation of blockage or obstruction with more than 25% of bowel movements
5. need to use manual maneuvers to facilitate evacuation of stool with more than 25% of BMs, and
6. less than 3 bowel movements per week.



Myth 2: Fecal incontinence is diarrhea

Fecal incontinence (FI) occurs in up to 21% of older people living at home and over 50% of LTC residents. FI increases with age, is higher in older men than women and can be permanent or temporary. Double incontinence (fecal and urinary) occurs 12 times more often than fecal incontinence alone, with 50% to 70% of residents experiencing both. The combination of urinary and fecal incontinence is the second most common reason for LTC placement.

What is it? **FI is the involuntary passage of fecal material through the anus.** The function of the rectum is to act as a reservoir for formed stool but it can't cope with liquid or irritant substances. FI varies from mere soiling of undergarments by liquid stools to loss of control of even solid stools. FI isn't diarrhea. Residents may complain of diarrhea when in fact, it's FI. The most common cause of FI is constipation followed by anorectal muscle weakness due to constant strain- ing , post surgery, childbirth, severe diarrhea, infection, laxative abuse, stroke, medications, colorectal diseases, diabetes, Parkinson's, MS, spinal injury, dementia, immobility and/or functional problems.

More information on This and Other Best Practices

- Contact your **Regional LTC Best Practices Coordinator.** They can help you with Best Practices Info for LTC. Find them at:
- **www.rgpc.ca** Click on Long Term Care
- **www.shrtn.on.ca** Click on Seniors Health
- Check out the **Hamilton Long Term Care Resource Centre www.rgpc.ca**
- Surf the Web for BPGs Some sites and resources are listed on pg 2.

RGPs OF ONTARIO Centres of Excellence in Inter-professional Practice and Collaborative Geriatric Care and The Long Term Care Resource Centre Hamilton

Hamilton LTC Resource Centre

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Editor
Mary-Lou van der Horst
Geriatric Nursing /Knowledge Translation Consultant (GIIC)
Regional Geriatric Program - Central
St. Peter's Hospital
88 Maplewood Ave, Hamilton, ON. L8M 1W9
marylou1harold@xplornet.com

Library Support Services
Shannon Buckley
SHRTN Library Services-Hamilton
Long Term Care Resource Centre
88 Maplewood Ave, Hamilton ON L8M 1W9
SBuckley@stpetes.ca

Find it on the Web at www.rgpc.ca or www.shrtn.on.ca

Myth 3: Fecal impaction doesn't cause fecal incontinence

A major problem associated with constipation is the development of **fecal impaction**. Fecal impaction needs special management which often involves using enemas to clear the bowel; in addition to stimulant laxatives. When normal bowel function is restored, it's important to resume constipation prevention strategies and discontinue as many laxatives as possible. **Fecal impaction can lead to bowel obstruction**. Most often, **fecal incontinence** is due to **fecal impaction** which is reported in 42% of older adults who have chronic constipation, are receiving large doses of laxatives resulting in the **seepage of stools** around the bowel obstruction. This **seepage** or **overflow fecal incontinence** is very common in residents who are cognitively impaired and/or bedridden. Risk factors for overflow fecal incontinence include

- Medications – narcotics, antipsychotics, antidepressants, calcium channel blockers, diuretics
- Metabolic abnormalities – hypothyroidism, high calcium, low potassium
- Inadequate fiber and water intake
- Immobility and inadequate toileting facilities
- Delirium

RED FLAGs

in persons with constipation .....

While most older persons with constipation can be treated symptomatically, persons who have any of the following conditions should have their causes of constipation looked at more rigorously, for:

* Sudden onset
* Sudden change
* Abdominal pain
* No bowel movement in 3 or more days
* Change in vitals signs
* Weight loss
* Family/personal history of colon cancer
* Rectal bleeding
* Liquid stools
* No bowel sounds
* Iron deficiency anemia

Myth 4: Bowel programs don't work

Bowel care programs do help to prevent constipation, fecal impaction, incontinence and bowel obstructions. Develop a workable proactive bowel management program that's realistic with goals to . . .

- Improve residents' quality of life and dignity as bowel problems can cause decline in QOL, functional ability, social interactions, and pain
- Promote multidisciplinary involvement to develop individualized care approaches
- Prevention: Modify factors where possible including increasing dietary fibre and fluid intake, laxative reductions, review medications, improve activity levels, regular timing and positioning on the toilet.
- Assess regularly—do Bowel assessments on admission, quarterly and with changes
- Educate staff on bowel functioning and bowel care
- Document monitoring of diet, fluids, bowel/toileting habits, mobility/exercise, behaviours
- Have acute and chronic bowel management strategies
- If no bowel movement on day 3, laxatives are needed
- Avoid frequent or prolonged use of laxatives
- Minimize the use of stimulants such as Senna for long term use of chronic constipation as it can lead to diarrhea, dehydration, and a cathartic bowel.

Constipation in Palliating Residents is a common and troublesome side effect from opioid medications; ietary, motility and disease factors. It can cause severe discomfort and ill health. Unfortunately, there is insufficient research information to determine the "best" management of constipation in palliative care. Laxatives are used and opioid rotation is recommended where laxatives fail.

*** Bowel Care TIPS ***

CONSTIPATION-Fibre should not be used in residents who are immobile or who are receiving inadequate fluid.
CONSTIPATION- manage dehydration
FECAL INCONTINENCE- Residents with cognitive impairment benefit the most from habit training, prompting, redirection
LAXATIVES When constipation resolves, return to prevention strategies and reduce laxative use

Check out these Best Practices & Guidelines. Answers to the Myths came from them. Find out more!

Canadian:

Registered Nurses Association of Ontario. (2005). Prevention of constipation in the older adult population. Toronto, ON: RNAO. www.rnao.org

Others:

American Medical Directors Association (2006). Gastrointestinal disorders in the long-term care setting. Columbia, MD: AMDA.www.amda.com

Hinrichs, M., Huseboe, J., & Titler, M.G. (1998). Evidence-based practice guideline. Management of constipation. Iowa City, Iowa: University of Iowa Gerontological Nursing Interventions Research Center. www.nursing.uiowa.edu

Gilding, M., Weedon, K., Schofield, S., et al. (1999). Best practice: Management of constipation in older adults. Evidence based practice information sheets for health professionals. North Terrace, South Australia, Australia: The Joanna Briggs Institute for Evidence Based Nursing and Midwifery. www.joannabriggs.edu.au

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