Joint Trust Guideline for Inpatient Bowel Care and Laxatives in Older People

A clinical guideline recommended for use

For Use in: Norfolk and Norwich University Hospital
By: Nursing and Medical Staff
For: Older people (80+ Years old)
Division responsible for document: Medical Division (Including Emergency)
Key words: Constipation, Bowel care, Laxatives, Older Peoples Medicine
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Assessed and approved by the: Clinical Guidelines Assessment panel (CGAP)
If approved by committee or Governance Lead Chair’s Action; tick here ✓
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To be reviewed before: This document remains current after this date but will be under review 19/10/2020
To be reviewed by: Dr Garry Dawson
Reference and / or Trust Docs ID No: 10210
Version No: 2
Description of changes: Changes are: actulose amended to Laxido. Other agents to consider include section amended and references updated.
Compliance links: (is there any NICE related to guidance) None
If Yes - does the strategy/policy deviate from the recommendations of NICE? N/A
Quick reference guideline

PATIENT CONSTIPATED
Bowel care documented in care plan

CLINICAL EVIDENCE OF OBSTRUCTION?

No

ORAL LAXATIVES
1st line- ISO-OSMOTICS/OSMOTICS (e.g. Laxido® 1-2 sachets BD) (Or if not tolerated 10-15ml Lactulose BD)
–In combination with STIMULANT (e.g.; Senna 1-2 tablets OD)
OR if not tolerated Bisodyl 5-10mg OD
(Sodium Docusate 100-200mg BD) can be1st line if patient immobile, dehydrated or struggles with fluid volume.

INCREASE DOSE/ADD ON THERAPY (daily if no bowel action)

No/unsatisfactory bowel motion (Bristol Stool Chart Type 3) within 24 hours of dose increase

CONSIDER SURGICAL REFERRAL (after appropriate imaging)

CONTINUE CURRENT ORAL LAXATIVES
Monitor for adverse effects (may need to consider laxative switch or ↓ dose)

CONTINUE CURRENT ORAL LAXATIVES & CONSIDER RECTAL MEASURES

DIGITAL RECTAL EXAMINATION
Consider purge orally for faecal impaction (Up to eight sachets Laxido® daily for up to 3 days)

HARD FAECES
Glycerol sup
If no response:
Phosphate enema
If no response:
Arachis Oil enema (do not use in patients with nut allergy)

SOFT FAECES
Glycerol supp
If no response:
Bisacodyl suppository
If no response:
Microlax® enema
If no response:
Phosphate enema

Stool high in rectum
Phosphate enema using long rectal tube and osmotic laxative

No/unsatisfactory bowel motion (Bristol Stool Chart Type 3) within 24 hours

CONSIDER SURGICAL REFERRAL (after appropriate imaging)

Avoid bulk forming laxatives (e.g. Fybogel®) in older patients unless usual laxatives on admission

Avoid liquid paraffin containing laxatives in older people

Consider alternative less constipating medication

Encourage patient’s choice of fluids, all day

Optimise patient’s mobility and toilet height with input from physiotherapist and occupational therapist

Optimise toilet privacy

Rationalise analgesia (pain team review may be considered)
Key points

- All older people presenting to hospital should have a detailed assessment of bowel function on admission and bowel habit documented daily utilising the medical notes, care plan and observation chart.

- Constipation/impaction can present atypically in older people - consider it in presentations of acute back pain, urinary retention, acute delirium/confusion, fever, nausea and diarrhoea (overflow).

- Diet and lifestyle modifications are often ineffective to manage constipation in the elderly and a multifactorial approach is suggested.

- Older people taking regular laxatives in the community should always have these continued whilst an inpatient unless specific reasons are documented in the medical notes and/or. This should form part of the medicine reconciliation.

- All older patients prescribed opioids especially in the post-operative period should be co-prescribed laxatives (Laxido T BD and senna 7.5mg ON as first line).

- Meptazinol 200mg TDS is the first choice opioid for mild to moderate pain in older people.

- Digital Rectal Examination (DRE) should be performed on all patients whose presenting complaint requiring admission is constipation and should be performed in all patients when constipation is not resolving with first line laxatives prior to rectal measures.

- Bulk forming laxatives and paraffin based laxatives are not recommended as first line laxatives in hospitalised older people.

- First line laxatives are:
  - Laxido® 1-2 sachets BD (in immobile patients with poor fluid intake who can tolerate 250mL dosing)
  - OR
  - Lactulose 10-15mLs BD (in immobile patients with adequate fluid intake where Laxido is not tolerated)
  - Docusate 200mg BD (in immobile, dehydrated patients or those who cannot tolerate larger fluid volumes but it has limited efficacy as a monotherapy)
  - AND
  - Stimulant laxatives such as Senna should be co-prescribed

- Non-pharmacological measures such as increased dietary fibre intake, exercise, adequate fluid intake and withdrawal of culprit medications should be encouraged.

- Toilet privacy, toilet height and appropriate aids and mobility should be optimised within the MDT. If safe the patient should be encouraged to mobilise to the toilet and avoid commode or bed pan use whenever possible.
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Objective

This guideline was written to give clear guidance to nursing and medical staff for documentation of bowel care and the management of acute constipation in older inpatients at the Norfolk and Norwich University Hospital.

1. To provide guidance on how to assess and document bowel care on admission and during inpatient stay
2. To unify laxative prescribing within the Trust in older patients with constipation based on most recent evidence and guidelines
3. To encourage medicine reconciliation so regular laxatives are continued whilst an inpatient
4. To encourage laxative co-prescribing with opioids in older patients

Rationale

Constipation is common in the elderly population and is estimated to affect around 40% of people over 75 years in the community and over 70% of nursing home residents and hospital inpatients. Due to the high prevalence in older patients, bowel care and the possibility of constipation should be assessed on admission and daily whilst an inpatient by both nursing and medical staff. Despite being a common condition there is surprisingly little evidence available on which to base management decisions and laxative preference varies significantly amongst those caring for older patients.

Broad recommendations

See key points for summary

Documenting Bowel Care in Older Inpatients

All older people presenting to hospital should have a detailed assessment of bowel function on admission. This should be documented by medical staff in the initial clerking to include any history of constipation/faecal incontinence, when bowels last opened, any change in bowel habit and a medication history of regular laxatives (including medicine reconciliation from pharmacy staff, previous electronic discharge letters or care home records).

Nursing staff should assess bowel care on admission and document this in the patient’s care plan (see appendix 1). A record of the patient’s daily bowel habit should be documented on the observations chart as either BO (bowels open) or BNO (bowels not open) (see appendix 2) and a Bristol Stool Chart completed and filed in the bedside notes (see appendix 3).

If any issues are raised as part of this process they should be discussed within the ward MDT and appropriate laxatives prescribed.
Constipation in Older People

Constipation is defined as passage of small hard faeces infrequently and with difficulty. The World Gastroenterology Organisation practice guidelines are based on the Rome III Criteria which consist of 2 or more of the following in any 12 week period during the previous 12 months:

- Fewer than 3 bowel movements per week
- Hard stool in more than 25% bowel motions
- Sense of incomplete evacuation in more than 25% of bowel motions
- Excessive straining in more than 25% bowel motions
- A need for digital manipulation to facilitate evacuation

There are certain clinical features that may accompany constipation including pain (commonly abdominal or back pain), nausea and vomiting, urinary tract obstruction, diarrhoea (possibly overflow), bloating, flatulence and fever. There may be acute delirium and confusion, which may be caused by constipation/impaction.

Older people are more prone to constipation which often results from a combination of risk factors such as reduced fibre, food and fluid intake as well as decreased physical activity due to chronic diseases and multiple medications. Unfortunately simple non-drug measures such as increasing dietary fibre, exercise and fluid intake are often not sufficient to treat constipation in hospitalised older people.

Polypharmacy and Opioids in Older People

Polypharmacy is common in older people and can contribute to constipation; below is a list of common medications that can contribute to the problem, many of which can be withheld for a short time until the constipation resolves:

- Analgesics (non-steroidal anti-inflammatory drugs (NSAIDs), opioids)
- Antacids (containing aluminium or calcium)
- Anticholinergics (oxybutynin)
- Antidepressants (monoamine oxidase inhibitors, tricyclic antidepressants)*
- Antihistamines
- Antihypertensives (calcium channel blockers)
- Anti-motility drugs (loperamide)
- Antipsychotics*
- Antispasmodics
- Calcium
- Diuretics (thiazides)
- Iron

*Caution stopping these drugs without senior advice.

Opioids are often prescribed for older people during their inpatient stay. The pathophysiology of constipation due to opioids is well described. Possible aetiologies include increased anal sphincter tone, reduced peristalsis in the small intestine and
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colon, increased electrolyte and water absorption and impaired defaecation response. Two opioid receptors, µ and δ, are located on gut smooth muscle and have the largest role in gastrointestinal motility, with µ directly affecting the myenteric plexus.

The preferred opioid used within the Older Peoples Medicine department is meptazinol (200mg TDS) for mild to moderate pain as this is generally well tolerated in the elderly with less associated constipation. Codeine phosphate and tramadol should be avoided in older people due to associated risk of constipation and falls. All older patients who are prescribed opioids should be co-prescribed laxatives unless there is a clear reason for not doing so. This is especially important in post-operative older patients who will have several factors predisposing them to constipation including poor mobility, reduced fluid intake, pain and opioid prescribing. The first line choice of laxative for older inpatients on opioids is Laxido co-prescribed with Senna

Laxatives

See quick reference guide for summary on laxative prescribing.

Types of laxatives

- Bulk forming laxatives (Fybogel®/ispaghula husk)
- Iso-osmotic laxatives (Laxido®)
- Osmotic laxatives (lactulose)
- Stool softeners (docusate, liquid paraffin)
- Stimulant laxatives (Senna®, bisacodyl)

Onset of Action

- Bisacodyl - 10–12 hours
- Bisacodyl suppositories - 20–60 mins
- Docusate - 12–72 hours
- Glycerol suppositories - 1–6 hours
- Lactulose - 48 hours
- Laxido® - 24–72 hours
- Microlax® enema - 20 minutes
- Phosphate enema - 20 minutes
- Senna - 8–12 hours

Bulk-forming laxatives absorb water in the gastrointestinal tract to form a mucilaginous mass, which increases the volume of the faeces to promote peristalsis. They act as soluble fibre and have the effects of dietary fibre. Despite being a good first line choice in ambulant well-hydrated patients they are less effective in hospitalised older people and require patients to drink over 1 litre of fluid a day. They should not be given in faecal impaction and are not compatible with NG or PEG tubes.
Iso-osmotic laxatives contain high molecular weight macrogol which is unchanged along the passage of the gut. This works by increasing the stool volume, thereby directly triggering colonic propulsive activity and defaecation via neuromuscular pathways. It is suitable in poorly ambulant patients with low fluid intake making it an ideal laxative for most hospitalised older people. It does require 125mL of water with each sachet and some patients may struggle with the larger volumes of fluid to drink. It can also be used in faecal impaction as an oral purge prior to rectal measures (up to eight sachets a day dissolved in 1 litre of water and drunk over 6 hours for up to 3 days).

Osmotic laxatives include lactulose which is a disaccharide that cannot be hydrolysed in the small intestine so reaches the colon virtually unchanged. Here it is metabolised by colonic bacteria to short chain fatty acids and gas. The end result is a change in osmotic pressure and acidification of the colonic contents, resulting in an increase in stool water content, softening the stool and promoting increased peristalsis and bowel evacuation. Although it is suitable in poorly ambulant patients, those taking osmotic laxatives should maintain adequate fluid intake during therapy. The liquid dose is relatively small (10-15mLs) and manageable for most older people.

Stool softeners either act as lubricants, such as liquid paraffin, or as surface-wetting agents which have a detergent-like action, such as docusate. They help fluid to mix into the stool to soften it and make defaecation easier. Liquid paraffin containing laxatives are not recommended in older people as it may reduce absorption of fat-soluble vitamins and cause lipid pneumonia if aspirated.

Docusate is a suitable choice in dehydrated and immobile patients so is ideal for the majority of hospitalised older people. It does however have a limited effectiveness when used as monotherapy and ideally should be used with other agents.

Stimulant laxatives provoke an irritant effect to stimulate intestinal motility. They should be used as add-on therapy to first line laxatives and not used for longer than 3 months.

Other agents to consider include:

1) Prucalopride has only been approved for use in the trust for symptomatic treatment of chronic constipation (of at least six months duration) in women in whom at least two laxatives have failed to provide adequate relief in accordance with NICE guidelines. It’s evidence is limited in the elderly

2) Danthron containing stimulant laxatives (e.g.co-danthramer) are restricted by licence to use in “terminally ill” patients only

3) Peripherally selective opioid antagonists (e.g. naloxegol) have only been approved for use in the trust as an option for treating opioid induced constipation in adults whose constipation has not adequately responded to laxatives, in accordance with NICE guidelines.
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4) Targinact (oxycodone / naloxone) is a non-formulary drug in the Norfolk and Norwich Hospital and reserved for specialist palliative care use so is beyond the scope of discussion of this document.

Rectal measures should be reserved for when combination therapy of oral laxatives has failed or the patient has faecal impaction and is unable to tolerate an iso-osmotic oral purge. A digital rectal examination should always be performed as the findings will dictate the choice of therapy.

Soft stools may be evacuated by glycerol suppositories and if ineffective a stimulant such as bisacodyl suppositories may be used. If these fail then Micralax® is third line then lastly a phosphate enema.

Hard stools can be softened with glycerol suppositories and if this is unsuccessful then a phosphate enema may be used. An arachis oil enema (contraindicated in peanut allergy) can be given overnight to soften very hard stools followed by a phosphate enema via a rectal tube the next morning.

Faecal impaction should be treated with a sodium phosphate enema.

Manual disimpaction This procedure is a last resort. It should be performed with sedation ideally in theatres. There are a number of concerns that manual disimpaction may damage the anal sphincter, resulting in sphincter weakness and resultant faecal incontinence. It can also cause profound vagal stimulation and resultant bradycardia.

Clinical Audit Standards

This guideline was reviewed using evidence based on a bowel documentation audit from June 2017. We suggest re-auditing within the Older Peoples Medicine department in the spring of 2018.
Audit standards will include;

- All OPM patients should have a detailed assessment of bowel function on admission
- To determine whether documentation of patients bowel pattern is recorded daily from admission
- To determine whether laxatives are co prescribed with opioids in older people
- To ensure that patients continue their normal aperients on admission

Summary of development and consultation process undertaken before registration and dissemination

The authors listed above drafted this document on behalf of the Older People’s Medicine Department which has agreed the final content. During its initial development it was circulated for comment to Consultants, Senior Pharmacists and Senior Nurses within the Older Peoples Medicine department at the Norfolk and Norwich University Hospitals NHS Foundation Trust. This feedback has been incorporated into this final document.
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This version has been endorsed by the Clinical Guidelines Assessment Panel.

**Distribution list/ dissemination method**

Available via the NNUH intranet trust guidelines pages.
References/ source documents

1. D Giorgio et al. (2015), Chronic constipation in the elderly: a primer for the gastroenterologist. *BMC Gastroenterology, 15*:130


### Appendix 1: Patient care plan

#### INITIAL NURSING ASSESSMENT

<table>
<thead>
<tr>
<th>Patient Label or Name:</th>
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#### Care Domains & Assessment Prompts

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<th>Usual Health</th>
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<td>2. Communication</td>
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<td>13. Infection Control</td>
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#### Information taken from:

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- Other: [ ]

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Nursing Assessment & Plans of Care - Authors: NNUHFT Staff - Sept 2013 V.1.0
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Appendix 2: Daily monitoring of bowels on observations chart

<table>
<thead>
<tr>
<th>DATE</th>
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**Observations Frequency:**

- **O₂ Code:**
  - **N** = Nasal cannula
  - **SM** = Simple Mask
  - **RM** = Reservoir Mask
  - **V** = Venturi
  - **H** = Humidified
  - **A** = Air

**Segment:**

- **Record:**
  - **O₂:** Insp O₂: (Record flow rate in Litres (L))
  - **Target Oxygen Saturation:**

**Observation Chart**

- **Name:**
- **Registration No.:**
- **NHS Number:**
- **Date of Birth:**

- **SATS %**
  - **O₂ Code**
  - **Insp O₂**

- **Weight**
  - **Urine pH:**
  - **Glucose:**
  - **Ketones:**
  - **Sp. Gravity:**
  - **Blood:**
  - **Protein:**
  - **Nitrite:**
  - **Leucocytes:**

- **Respiratory:**
  - **Type of Stool:**
  - **Early Warning Score Below & If EWS Trigger 4 or More Document Actions Over Page**

- **Temp:**
  - **Systolic BP:**
  - **Pulse:**
  - **Respiratory:**
  - **AVPU:**
  - **Urine:**
  - **Total:**
  - **Sign Initials:**

**Notes:**

- **V5 revised Jan 2014**
- **NNR775**
### Appendix 3: Bristol stool chart

| Date (dd/mm/yy) | Time | Consistency (Please use Bristol Stool Chart to gauge type and tick relevant box) | Description of Stool | Specimen Sent & Type of Test (Patient must be isolated if specimen requested for H. pylori or C. diff (for Nosocomial speak to IPBC)) | Signature & Print Name |
|-----------------|------|---------------------------------------------------------------------------------|----------------------|----------------------------------------------------------------------------------------------------------------|--|---------------------|
| Date            |      |                                                                                 |                      |                                                                                                              |                          |
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*BMNO = Bowels not opened*  

Infection Prevention & Control—September 2013

*If photocopying/printing for ward, please ensure continuation sheet is copied onto back of sheet.*