Constipation in palliative care Clinical Update

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In every palliative care nursing crowd


A HAPPY BOWEL, A COMFORTABLE YOU
PALLIATIVE CARE FOCUSED ON COMFORT
PREVENT CONSTIPATION
We rule with fibre, fluids and a plan!
Every bowel movement matters. Comfort is our crown.
RELIEVE DISCOMFORT
OUR TOOLS FOR SUCCESS
FIBRE (if appropriate)
FLUIDS (if appropriate)
MOVEMENT (as able)
ROUTINE
TOILET TIME & PRIVACY
BOWEL KING
BOWEL QUEEN
BOWEL PLAN
ASSESS
PREVENT
TREAT
REVIEW
COMFORT
SOFT, COMFORTABLE & REGULAR IS OUR GOAL
OPEN GATE TO COMFORT
LAXATIVES (stool softeners & laxatives as needed)
HYDRATION
KEEPING THINGS MOVING!
NO ROOM FOR STOOL BLOCK!
IN PALLIATIVE CARE, WE:
LISTEN
ANTICIPATE
PERSONALISE
RELIEVE
REASSESS
COMFORT IS OUR MISSION
• RELIEF • DIGNITY • QUALITY OF LIFE •
YOU MATTER. WE CARE.

Constipation the poor cousin to pain?

Do we apply the biopsychosocial model of holistic assessment in palliative care to the symptom?

Definition of constipation

Lack of agreement on this definition

Means different things to different people

Health professionals use objective criteria- which includes the use of guidelines, assessment tools, physical assessments

Patients and carers have the lived experience of it- what it means to them in the day to day- how what's happening today or this week differs from usually happens

Which is more meaningful?

Is constipation what the patient says it is? (sound familiar?)

It’s a combination of both the objective and subjective information.

It’s how we tease it out, the story of constipation, from the person and family/carer we are sitting with.

It’s the Art of Palliative Care

Offer help if they are constipated

If not constipated- enquire further

If no bowels open for three days, show concern and enquire further

Assessment of constipation

Determine presence and severity of constipation.

Identify a cause for the constipation.

Might involve an assessment tool- scale like Bristol Stool From Chart.

Causes of constipation in palliative care

Slow gut transit times

Functional decline, dehydration, change in diet, Hypercalcaemia, mechanical cause

Treatments- medications- opioids, anticholinergics, diuretics, anti cancer treatments

Decreased rectal/anal muscle power

Anorexia/cachexia, mechanical factors e.g., anal fissure, neurological causes e.g., cord compression, environmental factors e.g., adequate privacy

What we, palliative care nurses, do well…

Central to the assessment and management of constipation (especially opioid induced constipation).

Responsible for documentation of bowel care.

There is a gap in the understanding of the patient and carer perspective and experience of constipation and the associated distress of the symptom when compared to the clinician perspective of the lived experience.

Do we minimise the experience of constipation to the number of bowel movements had in a week and consistency of those stools to the Bristol stool chart?

Do we make the management of constipation seem easy, the management seem pretty straight forward?

We feel deeply connected to the management of pain, to the outcome of pain management.

Is it the same for constipation?

Are we lacking the holistic assessment for constipation that we pride ourselves on?

Consider –

The pain and bloating from constipation

The lack of appetite from not opening your bowels for 4 days

The pressure, bleeding and tearing when trying to push through a hard stool

Dreading going to the loo- not sure what will happen

Anxiety creating a cluster of other feelings- anger, short tempered, embarrassment, trapped, lethargy…

For the carer

Very involved in the management of constipation

Can see the distress and stress of this symptom on the person

Is witness to the symptom being minimised time and again by health professionals

Is often left managing the symptom with an array of pharmaceutical choices..

When was the last time…

You had a conversation about the complexity of constipation for a patient and carer?

Did you initiate the conversation or was if a series of short, sharp questions seeking short, sharp answers?

Are we waiting for the patient or carer to start the conversation?

Are we hiding behind our objective assessments?

Do we ask about preventative strategies?

How much time do we give to these aspects of the management of constipation?

Adequate hydration

Dietary considerations

Exercise

Acupuncture

Abdominal massage

Medication review

Medication review

Analgesics

Antimuscarinics

Antidepressants

Antipsychotics

Antiepileptics

Antispasmodics

Antihistamines

Diuretics

Focus on the pharmacology

We certainly have some biases in this space

I am also guilty of this and perhaps we need to reflect upon this for a moment

Does your health care setting have a guideline for managing constipation..

No bowels open for three days then…..

The hand that prescribes the opioids prescribes the …. (how often does that happen?)

Follow a recipe for managing potential constipation from medications…

Recipes make good cakes, but they are not good for critical thinking in palliative care.

Stimulant laxative	Senna tablets or Dulcolax drops
Osmotic/surface wetting laxative	Movicol, lactulose, coloxyl with senna
Suppository or enema if rectum full is loaded	Fleet, bisacodyl, Microlax
Peripherally acting μ opioid receptor antagonists (PAMORAs)	Methylnaltrexone

OFFICIAL: Sensitive – Personal

Do we adequately explain why we are recommending a particular regimen?

When someone is in hospital do we take the time to talk about the mechanism of action of a particular aperient?

Do we pass over preventative strategies as too hard or not tolerable or not sustainable?

Do we minimise the privacy required around this symptom?

What other aspects of constipation need to be considered

We already manage the objective stuff pretty well.

Perhaps we have short-changed the patient and carers in the other stuff- the psychological, the social side of constipation in palliative care.

The bigger picture

Holistic impact

Patient experience and voice

Non-pharmacological and lifestyle aspects of managing constipation

These conversations can be golden moments

These can be the conversations that you'll remember

The ones you'll share over a glass of wine with colleagues at a palliative care conference in Adelaide

From some of my colleagues

A man who has a regular bowel motion is a happy man

Dustpan as bed pan

Pear juice (Golden valley in the can- very thick pear juice)

Christmas in your mouth…

Warm water in the morning

So, tasks to take home….

Definition of constipation for your service.

Which tools for assessment will be used?

Policies that include best practice for pharmacological and non-pharmacological strategies for management of constipation.

Best practice for documentation.

Ask patient and carer about their experience of the management of constipation.

Patient story

Patient little older than me

61

Morman

Married – 4 children

Metastatic colorectal cancer

Progressed through multiple lines of anti cancer treatment

Small bowel obstruction- surgical intervention

Profoundly changed the way his bowels worked

From clinician end-

All we heard was – loose bowels

Often needed to use gastro stop – alarm bells ringing

Using lots of opioids for cancer pain- Methadone, HYDROmorphone, Fentanyl

Largely managed by his wife

Managed all medications and deeply connected to the outcome of the medications

Constipation- an array of aperients

Aware of what constipation could cause

Lactulose, Movicol, Coloxyl with senna

One episode where 2L Movicol used- again managed largely by themselves

Much of what was happening was invisible to us

Dying

Functional changes

Distended abdomen

Suspected fracture on R leg- profound impact on what could be done at home

More involvement from community palliative care team

Complexity with personal care

Complexity with medications required for management of distress

Complexity around managing family expectation of personal care

Complexity around what family had to manage – with bowel care being a persistent problem

Dying day

Bowels continued to open

Personal care become too distressing

Burden outweighed the benefit

Reflection

What did we miss?

Much of the work was invisible to us

We made plenty of suggestions, enquired about outcomes

Perception was that the family was managing

Distress of the symptom when it mattered most

The nursing care on the day he died- profound effect on the family