Section 27

Bowel Conditions CAP

Problem

The Bowel Conditions CAP addresses three of the most common bowel conditions seen in older adults and disabled adults: constipation, diarrhea, and fecal incontinence.

A standard definition of constipation does not exist. Perhaps most commonly it is defined in the literature as not having a bowel movement for 3 or more days. If a person does not have a bowel movement for this period of time, usually the stool is harder than normal and may be difficult to expel. Some persons have hard stools or find it uncomfortable to have a bowel movement even if the frequency is daily. Such persons usually tell their physician that they are constipated. Constipation accounts for about 2.5 million physician visits per year. The prevalence of constipation in older persons living in the community is about 20%. Its high prevalence in older adults likely reflects in part changes in the colon associated with the aging process.

Diarrhea may refer to frequent bowel movements and/or to loose or watery stools. This condition, like the others, may be chronic or acute. Often it is associated with abdominal pain, fever, or other symptoms. Diarrhea may be just mildly annoying or life threatening. It may be caused by an acute infectious agent or may reflect a disease especially of the colon (for example, diverticulitis) or the small intestine. It may also be noted when the person's colon is impacted with stool and only loose stool is expelled.

Isolated fecal incontinence may be a rare occurrence. Often it is associated with one of the two previous complaints or it may be a chronic and exceptionally difficult issue to manage. On occasion it may reflect damage to the anal sphincter, especially if it is a frequent occurrence. It is especially of concern to many because of its impact on social functioning.

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Overall Goals of Care

- Recognize the existence of one or more of these three conditions and establish a cause for its existence.
- Address each in such a way that the person is able to function as normally as possible.
- Be able to monitor bowel function over time.

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Bowel Conditions CAP Trigger

The goal of this CAP is twofold: first, to facilitate improvement in bowel status whenever possible; and second, to prevent avoidable bowel decline. To identify these triggered groups, one must first calculate two risk summaries (decline and improvement).

- First, count the number of the following **Risk of Decline** criteria:

- Cognitive Skills for Daily Decision Making (Severely Impaired);
- Eating (Supervision through Total Dependence);
- Bed mobility (Total Dependence, Did not occur);
- Bladder continence (Incontinent);
- Easily distracted (Behavior different);
- Periods of altered perceptions or awareness of surroundings (Behavior different);
- Episodes of disorganized speech (Behavior different);
- Mental function varies over the course of the day (Behavior different).

- Second, count the number of the following **Risk of Improvement** items:
  - Toilet use (Independent through Limited Assistance);
  - Formal caregivers and direct care staff believe the person is capable of increased independence;
  - Pneumonia;
  - Deteriorated;
  - Bladder continence (Continent and Usually continent);
  - Hip fracture in the last 180 days.

TRIGGERED TO FACILITATE IMPROVEMENT

All of the following must be present:

- Risk of Decline count (from previous section) equal to 0 or 1, **and**
- Risk of Improvement count (from previous section) equal to 2 or higher, **and**
- Bowel continence: Infrequently incontinent to Incontinent

This group includes about 5% of persons in long-term care facilities, 7% of persons receiving home care, and less than 1% of older adults living independently in the community. In a long-term care facility setting, about 33% of the persons triggered into this group will improve over a 90-day period (while 19% will decline); the rate of improvement in home care is about 20% (while 6% will decline).

TRIGGERED TO PREVENT DECLINE

All of the following must be present:

- Risk of Decline count (from previous section) equal to 2 or higher, **and**
- Bowel continence: Not fully incontinent

This group includes about 15% of persons in long-term care facilities, 6% of persons receiving home care, and less than 1% of older adults living independently in the community. In a long-term care facility setting, about 30% of the persons triggered into this group will decline over a 90-day period (while 11% will improve); the rate of decline in home care is about 14% (while 13% will improve).

NOT TRIGGERED — All other persons. Some of these persons have bowel problems at the time of assessment, and would receive normal care for bowel problems when present.

Assessment and Care Planning

A person having any of these conditions must be evaluated to determine the duration of the symptom, its severity, and the presence of any other complaints. Look for indications of malaise, abdominal pain, fever, or the presence of blood in the stool or dark stools (which may reflect bleeding higher up in the GI tract). All persons with a significant change in bowel habits, fever, blood in the stool, associated pain, or persistent abnormalities require medical evaluation.

One or more of these three conditions may reflect a decline in mobility, a recent change in diet, the introduction of a new medication, decreased fluid intake (for any reason), or even excessive environmental heat.

Once the cause is determined, the key concern for optimal care planning is the promotion of a pattern of bowel function such that the person does not experience discomfort or any social inconvenience.

Bowel Problem Assessment

What is the history of the problem?

- How many bowel movements did the person have within the last few days? Is this pattern "normal" for the person? What was the consistency of the stool?
- Was there evidence of blood in the stool (either red stool or unusually dark stool)?
- If there was incontinence, was it a large amount of stool, or just a small amount? Was the person fully aware of the passage of the stool?
- Is there a history of anorectal or colonic surgery, or in a female, damage to the rectum at the time of delivery?
- Is there a history of intolerance to certain foods, especially milk?
- Has the person passed excessive amounts of gas or felt bloated?
- Did the person have a fever or experience malaise?
- Did the person vomit or have abdominal pain?
- Is there a recent change in the person's diet, fiber, or fluid intake?
- Does the person have a known condition, such as diverticulosis or diabetes, that might help explain the symptoms?
- What medications is the person taking? Have any new medications been started recently?
- Is there a history of laxative use and, if so, has it been excessive?

What are the characteristics of the stool?

- Description of stool type: consistency, color, unusual odors, presence of frank blood.
- Is the person straining when he or she tries to defecate?
- Does the person have pain associated with bowel movements?

What are the characteristics of the bowel pattern?

- Does the person have a pattern for moving his or her bowels?
- Is it different recently?
- Does the person need to share a bathroom, or is he or she otherwise not assured of privacy when using the toilet?

Care Planning Suggestions

Care plan suggestions for persons with constipation. Strategies for improving diet, activity, and bowel pattern can be woven into the daily life of the person.

- Especially if of recent onset, evaluation by a physician is indicated to rule out a colonic tumor or other such cause.
- Identify the person's bowel pattern. Record the person's bowel movements and ask about his or her bowel habits. If fecal impaction is indicated it may be necessary to perform a rectal exam to determine the presence of stool in the rectum.
- Identify the presence of hemorrhoids or anal fissures. Consult a physician and provide topical anesthetics as needed.
- Assess the person for the presence of dementia or depression. Persons with depression need to be referred for mental health services. Persons with a dementia will benefit from a habit-training or bowel-training program.
- Ask about the person's medications and any laxative or enema use. Anticholinergics, narcotics, calcium channel blockers, some incontinence medications, iron, diuretics, tranquilizers, and antacids can cause constipation. Excessive use of laxatives and enemas can increase problems with constipation.
- Ask about the person's daily diet. Provide fluids and encourage the person to increase fluid intake. Increasing fiber intake should be done slowly over a matter of a few weeks to a month.
- Encourage toileting opportunities. Provide a bedside commode or an elevated toilet seat. Remind the person to go to the toilet after breakfast, or after a meal, or whenever the person is most likely to move his or her bowels.
- Provide opportunities for the person to increase daily physical activity. Regular walking and other physical activities can help to decrease or eliminate constipation.

Care plan suggestions for persons with fecal incontinence:

- Referral to a physician is indicated especially if onset is recent or associated with blood in the stool.
- Encourage the person to have bowel evacuation at the same time each day.
- Determine the presence of neuromuscular weakness. Persons with this problem may benefit from elimination training. Administer a suppository 30 minutes prior to scheduled elimination.

- Establish and monitor a bowel regimen that includes fluids, diet modification, scheduling, stool softener, suppository, and digital stimulation.
- Assess for the presence of fecal impaction. Remove impaction if present.
- For persons with chronic diarrhea as the cause of fecal incontinence, the physician may prescribe loperamide as a helpful medication.
- For fecal incontinence due to rectal sphincter disturbances, biofeedback may be effective.
- Meticulous skin care is a priority after episodes of fecal incontinence.
- At times, it may be necessary to use pads or briefs.

Care plan suggestions for persons with diarrhea:

- If severe, acute, or associated with pain, blood in the stool, or fever, immediate medical referral is indicated.
- Has the person recently been started on a new medication?
- Has the person recently started tube feedings? Dilute the feedings or change the rate of feeding.
- Is lactose intolerance suspected? Remove all sources of lactose from the diet.
- Is an intestinal bacterial infection suspected? Obtain a stool specimen for analysis.
- Is a fecal impaction suspected? Obtain an abdominal flat plate x-ray. Remove fecal impaction if present.
- Provide plenty of fluids that are noncarbonated and nondairy. When diarrhea is persistent or present with vomiting, dehydration may soon follow.
- Is lactose intolerance suspected? Remove all sources of lactose from the diet.
- Is an intestinal bacterial infection suspected? Obtain a stool specimen for analysis.
- Medications for diarrhea:
  - For nonspecific diarrhea, the physician may prescribe treatment with psyllium, methylcellulose, or loperamide.
  - For infectious diarrhea, therapy is targeted to suspected or identified pathogens.
- Meticulous skin care is a priority after episodes of diarrhea.

Consideration of further evaluation:

- Once the existence of constipation, diarrhea, or fecal incontinence has been established, it will be necessary to determine whether further testing is required.

- In the person with an abrupt onset of severe diarrhea who had been taking antibiotics recently (for another reason), a stool culture and a test for the toxins of C difficile would be indicated.
- If the person is having crampy abdominal pain and even mild diarrhea, he or she might require a CT scan to rule out diverticulitis or other conditions.
- If blood, either red or black, has been noted, this usually requires further evaluation such as a colonoscopic study and perhaps studies of the esophagus, stomach, and small intestine as well.
- In a large number of persons, the problem is chronic and appropriate interventions can be implemented.

Additional Resources

American Medical Directors Association. 2006. Clinical practice guidelines: Gastrointestinal disorders in the long-term care setting. Columbia, MD.

Carpenito-Moyet L. 2004. *Nursing care plans and documentation*, 4th ed. Philadelphia, PA: Lippincott, Williams & Wilkins.

Finne-Soveri H, Sorbye LW, Jonsson PV, Carpenter GI, Bernabei R. 2007. Increased work-load associated with fecal incontinence among home care patients in 11 European countries. Accepted for publication in the *European Journal of Public Health*.

McGough Monks K. 2003. *Gastrointestinal system assessment in home health nursing*. St. Louis, MO: Mosby.

National Digestive Diseases Information Clearinghouse (NDDIC), Bethesda, MD: www.digestive.niddk.nih.gov/about/contact.htm

National Institute for Health and Clinical Excellence. 2007. NICE Guideline 49, Faecal incontinence. National Collaborating Center for Acute Care, London, England: www.nice.org.uk

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