



Virginia Department of  
Behavioral Health &  
Developmental Services

# Constipation and Bowel Obstructions

## Risk Awareness Training (RAT)

**Presented by:**

**The Virginia Department of Behavioral Health and  
Developmental Services**

**The Office of Integrated Health  
Health Supports Network**

# Objectives

1. Define constipation
2. List (2) common causes of constipation
3. State (2) complications of constipation
4. Define bowel obstruction
5. Identify (4) signs and symptoms of fecal impaction
6. Identify (3) caregiver recommendations
7. List two medical professionals that can help with assessing for bowel obstruction



# Who benefits from this training?

DSP's and caregivers- you will learn important risk factors associated with constipation and bowel obstructions, learn to recognize signs and symptoms, and the importance of recognition and reporting.

Support Coordinators-you will learn important risk factors associated with constipation and bowel obstruction, understand the signs and symptoms that DSP's and caregivers are going to recognize and provide in documentation, and learn diagnosis that may be associated with risk factors.

# Terms and Definitions

Normal bowel habits- each person's bowel habits are individualized. While some may eliminate every day, others may only have a bowel movement 3 times a week. Many factors contribute to frequency of bowel movements such as hydration, exercise, and mobility.

Constipation- is defined as difficulty passing stool. Having fewer than three (3) bowel movements a week. (Mayo Clinic, 2018)

Functional Constipation- is defined as having no anatomical or genetic defect that is the underlying cause. There is no organic cause. Cause may be associated with inadequate fluid intake or lack of fiber in diet. (Talley, 2004)

Organic Constipation- when there is an identifiable condition, disorder or diagnosis causing constipation. (Pashankar, 2005).

Chronic Constipation- is defined as painful bowel movements that are hard and lumpy, with less than two movements a week, and may have feeling of incomplete defecation of stool (Talley, 2004)

# Signs and Symptoms- Adults

- Passing fewer than (3) stools per week or fewer bowel movements than usual.
- Straining/grunting
- Stool smearing in underwear or briefs
- Extended periods of time sitting on toilet trying to pass stool
- Refusing to eat or drink
- Hard or dry stool
- Hard, protruding stomach
- Abdominal pain, cramping, bloating



# Signs and Symptoms- Children

- Fear of the bathroom or toilets (public bathrooms).
- Toilet training problems in young children.
- Older children ignoring the urge to pass stool.
- Reduced stool from eating a low-fiber diet, not eating often
- enough or not drinking enough fluids.
- Intolerance to cow's milk.
- Lack of physical activity.
- Side effects from certain medications.
- Pain from hemorrhoids.
- **Examples of rare, but serious, causes of constipation in children include:**
  - Hirschsprung's disease: A genetic condition that prevents the colon from working normally.
  - Thyroid conditions.
  - Problems with the spinal cord (cerebral palsy).
  - Malformations of the anus and rectum.
- (UVA Children's, n.d.)

# Common Causes of Organic Constipation



Organic Constipation- there is an identifiable condition, disorder or diagnosis causing constipation (Pashankar, 2005).

- Hypothyroidism
- Pseudo obstruction or rectal tumors
- Neurologic conditions such as Cerebral Palsy
- IBD- Inflammatory bowel disease
- Diabetes Mellitus
- Celiac disease
- Dysphagia (inadequate consumption of fiber and fluids)
- Congenital disorders such as Tay Sachs, Prader-Willi, Hirschprung Disease, Spina Bifida, Trisomy 13, Down Syndrome
- Congestive Heart Failure

# Common causes of Functional Constipation



Functional Constipation- is defined as having no anatomical or genetic defect that is the underlying cause. There is no organic cause (Talley, 2004)

- Inadequate fluid intake
- Inadequate fiber intake
- Disruption of regular diet
- Disruption of routine
- Inactivity or immobility
- Poor body alignment
- Absence of upright standing
- Consumption of large amounts of dairy products
- Stress
- Resistance to bowel movements
- Overuse of laxatives
- Depression
- Eating disorders

# Complications of Constipation

- Hemorrhoids
- Rectal bleeding
- Anal fissures (tears in skin around the anus)
- Rectal prolapse (the large intestine detaches inside the body and pushes out of the rectum)
- Fecal impaction (hard, dry stool is stuck in the body and unable to be expelled naturally)
- Diverticulitis

# Fecal Impaction vs Bowel Obstruction

## Fecal Impaction

Fecal impaction occurs when hard, dry stool cannot pass through the colon or rectum. Fecal impaction may be caused by using laxatives too often, using certain types of pain medicines, little or no physical activity over a long period, diet changes, or constipation that is not treated (NCI, n.d.).

## Bowel Obstruction

A bowel/intestinal blockage or obstruction occurs when something prevents the contents of the intestines from passing normally through the digestive tract. The problem causing the blockage can be inside or outside the intestine.

# Signs & Symptoms

## Fecal Impaction

- Constipation.
- Rectal discomfort.
- Anorexia
- Nausea and vomiting
- Abdominal pain
- Paradoxical diarrhea (Liquid stool leaks around the fecal mass, imitating incontinence)
- Urinary frequency and/or urinary overflow incontinence.
- Abdominal distention and tenderness.
- Fever.

## Bowel Obstruction

- Cramping.
- Abdominal pain.
- Nausea and vomiting.
- No gas passing through the rectum.
- A “tight” or firm and/or bloated abdomen, sometimes with abdominal tenderness.
- Rapid pulse and rapid breathing during episodes of cramps.
- Colon tumor
- Diarrhea resulting from liquid stool leaking around a partial bowel obstruction.

# Importance of reporting change

Prevalence of constipation in **the general population** is difficult to ascertain due to inaccurate reporting. (Garrigues, et al., 2004) estimates that the general public has an incidence rate between 2%-34%. The incidence among females and elderly are higher (Garrigues, et al., 2004).

Prevalence of constipation within **the intellectual disability population** is as high as 50% (Robertson, Baines, Emerson, & Hatton, 2017). Increase in behaviors can also be an indication of constipation.

Any changes noted in bowel habits should be reported. Individuals that take medications for constipation should be monitored. To report a change contact the nurse. If nursing is not available, contact the PCP or an Urgent Care if issue is found on a weekend. Delay in seeking care can result in complications.



# DSP's connect the dots....

- **Situation:** James lives with his parents. His communication skills are limited. He is incontinent of bowel and bladder and requires total assistance with hygiene. He has a history of chronic constipation and fecal impaction. The PCP has ordered Miralax daily to help soften and promote bowel movements. James' mother does not like to give Miralax because it makes hygiene more difficult and he often will have leakage from his adult brief. She prefers that it remain hard. James attends day support.

Way to go DSP! You recognized a change in status.

Example only:  
Follow your agency documentation standards.

**Example of a progress note:** 4/16/20 8:20am James arrives at DS with a frown on his face. Staff asked his mother about bowel movements in the last 2 days, since he has not had one while at DS. His mother states, he has not had one at home since last Friday, today is Wednesday. Mother states that she had not given him Miralax either. James' stomach appears bloated and he is refusing all food and drink. Staff reported to DS manager.

# DSP's connect the dots...

Use the RAT tool to help staff recognize risks and prompt changes within plans and support instructions. The RAT can help providers be proactive.

You are the boots on the ground! Based on your daily observations you may recognize a change in status that would require evaluation. If you notice any of the risk factors listed below for bowel obstruction, report and document quickly.

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If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **bowel obstruction** occurred in the past year. (Check all that apply.)

- Is prescribed laxatives or enemas (routine or PRN)
- Refuses to drink water
- Requires assistance to be fed (food or liquid)
- Is prescribed psychiatric and / or narcotic medications (routine or PRN)
- Has limited mobility
- Has diagnosis of neuromuscular disorder (Cerebral Palsy, Spina Bifida, Muscular Dystrophy)
- Has diagnosis of pica

# Caregiver Recommendations

The main management response to constipation in people with intellectual disability is laxative use, despite limited effectiveness. An improved evidence base is required to support the suggestion that an individualized, integrated bowel management program may reduce constipation and associated health conditions in people with intellectual disability (Robertson, Baines, Emerson, & Hatton, 2017).

**Initiate a bowel management program that includes:**

- 1) Having a consistent schedule in place for taking medicines regularly to prevent or relieve constipation
  - 2) Monitoring of bowel movement frequency, consistency, and volume.
  - 3) Documenting the findings of monitoring by utilizing a tool such as a bowel diary to record stool frequency and consistency.
- ❖ Discuss treatment strategies with the individual's primary care physician (PCP), including implementation of a bowel management guideline or protocol to ensure the individual receives the prescribed treatment and proper monitoring for prevention of complications.



# Diagnosis

- Diagnosing of constipation may require physical exams, lab tests and bowel monitoring. The following questions are usually considered, when observing a person's condition and treatment options:
  - What is the individual's normal bowel habits?
  - How long has the individual had difficulty with bowel movements?
  - When was the last time the individual had a bowel movement?
  - Is the individual passing gas?
  - Does the individual complain about abdominal or rectal pain when defecating/having a bowel movement?
  - Does the individual grimace or appear to be in pain when they are defecating/having a bowel movement?
- **Always contact the primary care physician (PCP) if the individual has not had a bowel movement in 3 days.**



# Diagnostic Tests

## Diagnostic Tests

- A general physical exam.
- A digital rectal exam.
- Blood tests. The primary care physician (PCP) might check for an underlying condition such as low thyroid levels (hypothyroidism) (Mayo Clinic, 2018).
- Examination of the rectum and lower or sigmoid colon (sigmoidoscopy).
- Examination of the rectum and entire colon (colonoscopy).
- Evaluation of anal sphincter muscle function (anorectal manometry).
- MRI (magnetic resonance imaging).

# Prevention is key



- ✓ Ensure that individuals are receiving high-fiber foods in diet (according to recommendations of 20-35grams per day)
- ✓ Avoid eating highly processed foods with low fiber content
- ✓ Drink plenty of fluids
- ✓ Stay active and plan activities that promote movement
- ✓ Assist individuals to establish a schedule (encourage bathroom breaks 20-30 minutes after meals)
- ✓ Allow plenty of time for bathroom breaks
- ✓ Follow positioning protocol to promote natural bowel motility
- ✓ Administer stool softeners and/or laxatives as prescribed by PCP
- ✓ Track bowel movement frequency, consistency, and volume. (See note)

**\*A constipation protocol should be established for individuals taking stool softeners, laxatives on a routine basis or history of bowel obstruction.\***

# Case Study

Meet Joey. He is 34 years old with limited verbal communication. He has a diagnosis of Cerebral Palsy, Autism, constipation. He is incontinent of bowel and bladder.

Today Joey's mother calls you to report that he is very agitated, biting her when she gets close, and refusing to eat or drink. She asks if REACH would be able to help her with his behavior. You ask if she has taken his temperature or if he appears to be in pain. She replies that he is angry with her and will not allow her to touch him. Since you have a good relationship with Joey, you tell her you will come by the home shortly.

Upon arrival you notice that Joey is very agitated and grimacing. You talk to him in a soothing voice and he allows you to touch his hand. His skin feels normal temperature. You notice a Miralax container sitting on the counter, and ask the mother if Joey has taken his medications today. She states "yes, but I only give him Miralax when he gets really constipated." You ask about his last bowel movement and she is unable to recall, but states she prefers for his stool to be less messy and easier to clean up. You notice that Joey's stomach looks bloated, you try to gently rub his stomach and he reacts by trying to bite you.



# Apply what you have learned

State (3) caregiver recommendations to avoid the complications of constipation the Individual experienced in the case study.

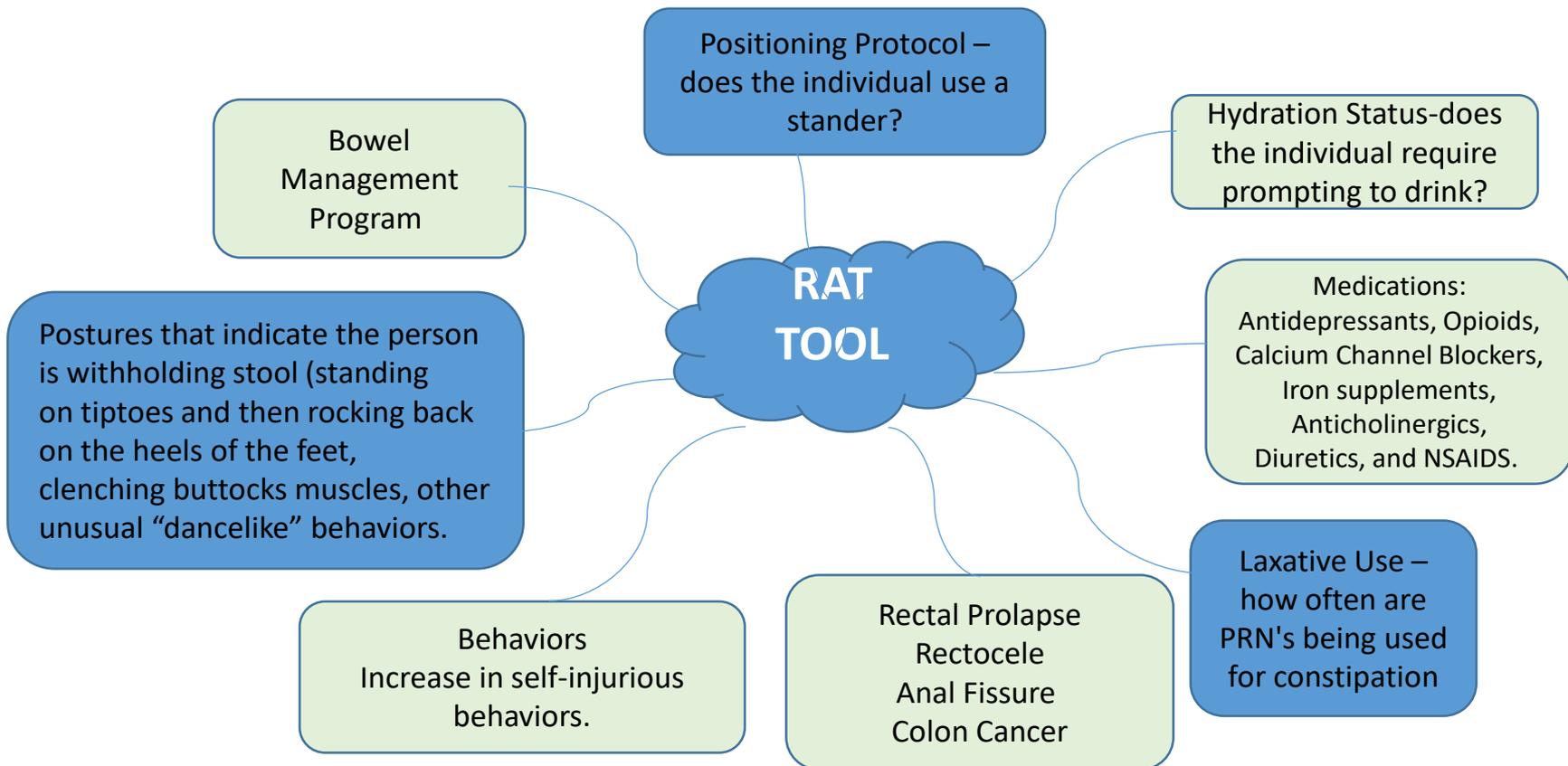
1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

# SC's connect the dots with the RAT Tool...

SC's- as you are completing the RAT tool keep in mind there are key diagnoses and situations you need to incorporate in discussion with providers and caregivers to ensure risk factors are being recognized.

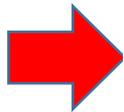


Prior to ISP meeting, review discharge summaries, medical reports, and health history for information.

**SECTION E-Bowel Obstruction**

*Bowel Obstruction is a partial or complete blockage of the bowel so that the contents of the intestine cannot pass through it.*

<b>Step 1:</b>	I. The person has been diagnosed by a medical professional with a <b>bowel obstruction</b> in this past year. If yes, the plan for support and/or prevention <b>must</b> be included in the ISP.	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
	II. The person has been diagnosed by a medical professional with <b>constipation</b> indicating the risk of a <b>bowel obstruction</b> in this past year.	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
	<i>If YES is checked above is there a plan for support?</i> If yes, the plan for support and/or prevention <b>must</b> be included in the ISP. <i>If YES is checked, skip Steps 2-5 and proceed to Section F- if NO is checked, complete Steps 2-5 below before proceeding to Section F.</i>	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>



During the ISP meeting ask all participants if they are aware of any risk factors listed in Step 2

**Step 2:** If the person does not meet the criteria in Step 1 (above), consider if these common indicators for **bowel obstruction** occurred in the past year. (Check all that apply.)

- Is prescribed laxatives or enemas (routine or PRN)
- Refuses to drink water
- Requires assistance to be fed (food or liquid)
- Is prescribed psychiatric and / or narcotic medications (routine or PRN)
- Has limited mobility
- Has diagnosis of neuromuscular disorder (Cerebral Palsy, Spina Bifida, Muscular Dystrophy)
- Has diagnosis of pica

**Step 3:** Based on the above risk indicators, a referral to a qualified professional is needed to evaluate and help develop a plan to reduce the **risk of bowel obstruction**. *If no risk indicators were selected, go to Section F.*

**Step 4:** What qualified professional has been identified to help? \_\_\_\_\_

**Step 5:** Who will contact them? \_\_\_\_\_ Target Date: \_\_\_\_\_

Think about all settings:  
Day Support, home,  
Community Engagement

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