The Management of Constipation in Adult Patients Receiving Palliative Care

Clinical Audit Tool

PALLIATIVE CARE

2015

This clinical audit tool accompanies the *Management of Constipation in Adult Patients Receiving Palliative Care NCEC National Clinical Guideline No. 10*

Issue date: 2015

This document is a support tool for clinical audit based on the NCEC guideline. It is not NCEC guidance.

This document can be used as a starting point for a local clinical audit project that **aims** to improve the information and support given to adults with advanced and progressive disease at risk of constipation. It contains:

- Clinical audit standards
- A data collection form
- An action plan template.

The audit standards and data collection form can be adapted to focus on a smaller part of the tool or expanded to include other local priorities.

The audit could be carried out in any service where specialist or non-specialist healthcare professionals are involved in the management of constipation in advanced illness. This includes GP practices, pharmacies and oncology or general medical wards.

The audit should involve clinical and non-clinical **stakeholders**, which may include medical staff of all grades, nurses, GPs, pharmacists, clinical audit staff and patients. Further information about patient and public involvement in clinical audit is available on the HSE website.

The audit **standards** are based on the *Management of Constipation in Adult Patients Receiving Palliative Care NCEC National Clinical Guideline No. 10*. In developing this tool consideration has been given to the clinical issues covered by the guideline and the potential challenges of data collection. There may be other recommendations within the guideline suitable for the development of audit standards or an audit project.

A **baseline assessment tool** is also available. This can help to compare practice with the guideline's recommendations and prioritise implementation activity, including clinical audit.

The audit standards in this document include a reference to the guideline **recommendation numbers**. Exceptions not explicitly referred to in the guideline can be added locally, for example, patients declining treatment.

The National Clinical Programme for Palliative Care recommends **compliance** of 100%. If this is not achievable an interim local target could be set, although 100% should remain the ultimate aim.

A **data collection form** should be completed for every patient at risk of constipation as a result of advanced illness. There is a section for demographic information that can be completed if this information is essential to the project. Patient identifiable information should never be recorded.

In the case of recommendation 2, the patient records are unlikely to explicitly record all communication with the patient. Therefore, rather than collecting data from patient records the form should be completed by the healthcare professional either during or shortly after their contact with the patient. The audit is intended to help healthcare professionals (or groups of healthcare professionals) to reflect on their own practice and make any identified improvements.

Following the audit, the **action plan template** can be used to develop and implement an action plan to take forward any recommendations made.

Re-audit is a key part of the clinical audit cycle, required to demonstrate that improvement has been achieved and sustained. Once a re-audit has been completed, organisations can submit case reports to the National Clinical Programme for Palliative Care in order to share the experience of putting guidance into practice.

For **further information** about clinical audit refer to a local clinical audit professional in your own organisation or the Quality and Patient Safety Clinical Audit webpage.

To **ask a question** about this clinical audit tool, or to **provide feedback** to help inform the development of future tools, please email the National Clinical Programme for Palliative Care at clinicalprogrammeadmin@rcpi.ie.

Recommendations for The Management of Constipation in Adult Patients Receiving Palliative Care

Recommendation	Guidance reference	Exceptions	Definitions
ASSESSMENT			
1. A thorough history and physical examination are recommended as essential components of the assessment process. *See data collection form question a, b and c*	1.1	Patients who are actively dying	
2. A digital rectal examination (DRE) is should be considered to exclude faecal impaction if it has been more than 3 days since the last bowel movement or if the patient complains of incomplete evacuation (following appropriate DRE training). *See data collection form question d*	1.3	Patients who decline this procedure; patients with a stoma; patients with prostatic abscesses or prostatitis. Caution is advised when considering a DRE in immuno-compromised or thrombocytopaenic patients.	
3. A plain film of the abdomen (PFA) is **not** recommended for routine evaluation but may be useful in combination with history and examination in certain patients. *See data collection form question e*	1.5		

PREVENTION			
4. Education on the importance of pharmacological and non-drug measures is essential to enable patients and caregivers to take an active role in constipation prevention. *See data collection form question f*	2.1	Patients with reduced level of consciousness; education should be tailored to the needs of individuals with cognitive impairment.	None

NON PHARMACOLOGICAL MANAGEMENT			
5a. Attention should be paid to the provision of optimised toileting while ensuring adequate privacy and dignity for all patients. 5b. Consideration should be given to lifestyle modification including the adjustment of diet and activity levels within a patient's limitations. *See data collection form question g*	3.1 3.2	None	None
PHARMACOLOGICAL MANAGEMENT			
6. The combination of a softening and a stimulating laxative is often required. Optimisation of a single laxative is recommended prior to the addition of a second agent. *See data collection form question h and i*	4.3	None	
7. The laxative dose should be titrated daily or alternate days according to response. *See data collection form question j*	4.4	None	
OPIOID INDUCED CONSTIPATION			
8. The development of opioid induced constipation should be anticipated. A bowel regimen should be initiated at the commencement of opioid therapy. *See data collection form question k*	5.1	Patients with stomas.	
9. In the management of opioid induced constipation, optimised monotherapy with a stimulant laxative is essential followed by the addition of a softener if	5.2		

required. *See data collection form question l*			
10. The use of opioid receptor antagonists under specialist guidance should be considered in patients whose treatment is resistant to conventional laxative therapy. *See data collection form question m*	5.4		
INTESTINAL OBSTRUCTION			
11. A stool softener should be considered in partial intestinal obstruction. Stimulant laxatives should be avoided. *See data collection form questions n and o*	6.1	None	
12. In complete intestinal obstruction, the use of all laxatives should be avoided as even softening laxatives have some peristaltic action. *See data collection form question p*	6.2	None	

Data collection form for 'The Management of Constipation in Adult Patients Receiving Palliative Care' clinical audit

The patient records are unlikely to explicitly record all communication with the patient. Therefore, rather than collecting data from patient records the form should be completed by the healthcare professional either during or shortly after their contact with the patient.

Audit ID:	Sex:	Age:

The audit ID should be an anonymous code. Patient identifiable information should never be recorded.

No	Question	Yes	No	NA/Notes (If N/A, state why)
ASSESSMENT				
a.	Was an appropriate bowel history taken on initial assessment? *Appropriately tailored assessment should be conducted on individuals who have impaired consciousness or cognition.* *Guidance recommendation 1.1*			
b.	Was a thorough physical examination conducted? *Guidance recommendation 1.1*			
c.	If constipation was identified, were the following components of a comprehensive assessment completed: • onset of symptoms • aggravating and alleviating factors • frequency and pattern of bowel motions • stool volume and appearance • nausea • abdominal discomfort • bloating • flatus • tenesmus *Appropriately tailored assessment should be conducted on individuals who have impaired consciousness or cognition.* *Guidance recommendation 1.1*			
d.	Was a digital rectal examination (DRE) considered to exclude faecal impaction in the following groups of patients: i. Where it has been more than 3 days since the last bowel movement? ii. If the patient complains of incomplete evacuation? *Guidance recommendation 1.3*			

No	Question	Yes	No	NA/Notes (If N/A, state why)
e.	Was a plain film of abdomen performed to assess for constipation? If yes, was it done so on the basis of specific consideration rather than being done "routinely" e.g. unreliable history, possibility of overflow diarrhoea? *Guidance recommendation 1.5*			
PREVENTION				
f.	Was education provided on bowel management strategies to enable patients and caregivers to take an active role in constipation prevention? *Guidance recommendation 2.1*			
NON PHARMACOLOGICAL STRATEGIES				
g.	Were non-pharmacological strategies considered in the constipation management plan (e.g. optimized toileting, diet and lifestyle adjustment)? *Guidance recommendation 3.1 and 3.2*			
PHARMACOLOGICAL MANAGEMENT (Consider When Laxatives are Indicated in Constipation Management)				
h.	In patients in whom more than one laxative was used, was a combination of a softening and a stimulating laxative used? *Guidance recommendation 4.3*			
i.	Was optimisation of a single laxative achieved prior to the addition of a second agent? *Guidance recommendation 4.3*			
j.	Where required, was the laxative dose titrated daily or alternate days according to response? *Guidance recommendation 4.4*			
OPIOID INDUCED CONSTIPATION (Consider in Patients Prescribed Opioids)				
k.	Was a bowel regimen initiated at the commencement of opioid therapy? *Guidance recommendation 5.1*			
l.	Was optimisation of a stimulant laxative achieved prior to the addition of a softening laxative? *Guidance recommendation 5.2*			
m.	Did the patient demonstrate resistance to conventional laxative therapy? If yes, was the use of an opioid receptor antagonist (e.g. methylnaltrexone, naloxegol, naloxone containing preparation) considered under specialist guidance? *Guidance recommendation 5.4*			

No	Question	Yes	No	NA/Notes (If N/A, state why)
INTESTINAL OBSTRUCTION (Consider if Established Diagnosis of Partial/ Complete Obstruction)				
n.	In patients with **partial intestinal obstruction**, was the use of a stool softener considered? *Guidance recommendation 6.1*			
o.	In patients with **partial intestinal obstruction**, were stimulant laxatives avoided? *Guidance recommendation 6.1*			
p.	In patients with **complete intestinal obstruction**, was the use of all laxatives avoided? *Guidance recommendation 6.2*			

Action plan for 'The Management of Constipation in Adult Patients Receiving Palliative Care' clinical audit

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name:	Title:	Contact:

The 'Actions required' should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the 'Comments' section.

Recommendation	**Actions required** (specify 'None', if none required)	**Action by date**	**Person responsible**	**Comments/action status** (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc)	**Change stage** (see Key)

When making improvements to practice, organisations may like to use the tools developed by the Palliative Care Clinical Programme to help improve palliative care practice.