The Management of Constipation in Adult Patients Receiving Palliative Care

Clinical Audit Tool

2015

PALLIATIVE CARE

This clinical audit tool accompanies the clinical guideline: 'The Management of Constipation in Adult Patients Receiving Palliative Care’ Issue date: 2015

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

The audit could be carried out in any service where specialist or non-specialist healthcare professionals prescribe medications for the management of cancer pain. For example, GP practices, pharmacies and

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 National Clinical Effectiveness Committee guideline for the management of constipation in adult patients receiving palliative care. 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

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

Recommendation	Guidance reference
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
2. A digital rectal examination (DRE) 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
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
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
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
7. The laxative dose should be titrated daily or alternate days according to response. *See data collection form question j*	4.4
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
9. In the management of opioid induced constipation, optimised monotherapy with a stimulant laxative is essential followed by the addition of a softener if required. *See data collection form question l*	5.2
10. The use of opioid receptor antagonists under specialist guidance should be considered in patients whose treatment is resistant to conventional laxative therapy.	5.4

See data collection form question m	
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
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

Exceptions	Definitions
Patients who are actively dying	
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.	
Patients with reduced level of consciousness; education should be tailored to the needs of individuals with cognitive impairment.	None
None	None
None	
None	
Patients with stomas.	

None	
None	

Audit Data for 'The Management of Constipation in Adult Patients F

			Question a	Question b
			Was an appropriate bowel history taken on initial assessment?	Was a thorough physical examination conducted?
Audit ID	**Age**	**Sex**		
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Yes			0	
No			0	
Total			0	
Percentage			#DIV/0!	

Demographics

Age range:	0 - 0

Male	0
Female	0

Receiving Palliative Care’ clinical audit

Question c	Question d	
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	Was a digital rectal examination (DRE) considered (following appropriate DRE traing) to exclude faecal impaction in the following groups of patients:	
	Patients in whom it has been more than 3 days since the last bowel movement?	If the patient complains of incomplete evacuation?

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Question e		Question f
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?	Was education provided on bowel management strategies to enable patients and caregivers to take an active role in constipation prevention?

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Question g	Question h	Question i
Were non-pharmacological strategies considered in the constipation management plan (e.g. optimized toileting, diet and lifestyle adjustment)?	In patients in whom more than one laxative was used, was a combination of a softening and a stimulating laxative used?	Was optimisation of a single laxative achieved prior to the addition of a second agent?

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Question j	Question k	Question l
Where required, was the laxative dose titrated daily or alternate days according to response?	Was a bowel regimen initiated at the commencement of opioid therapy?	Was optimisation of a stimulant laxative achieved prior to the addition of a softening laxative?

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Question m		Question n
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?	In patients with partial
		Was the use of a stool softener considered?

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Question o	Question p
intestinal obstruction:	In patients with complete intestinal obstruction, was the use of all laxatives avoided?
Were stimulant laxatives avoided?	

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Audit Title

The Management of Constipation in Adult Patients Receiving Palliative Care

Audit No: 0 Re-audit No: 0

Criteria	Audit results		Re-audit results	
ASSESSMENT				
1. A thorough history and physical examination are recommended as essential components of the assessment process	#DIV/0!	0/0	#DIV/0!	0/0
2. A digital rectal examination (DRE) 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 (follwoiung appropriate DRE training).	0%	/	#DIV/0!	0/0
	0%	/	#DIV/0!	0/0
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	#DIV/0!	0/0	#DIV/0!	0/0
PREVENTION				
4. Education on the importance of pharmacological and non-drug measures is essential to enable patients and caregivers to	#DIV/0!	0/0	#DIV/0!	0/0
NON PHARMACOLOGICAL MANAGEMENT				
5. Attention should be paid to the provision of optimised toileting	#DIV/0!	0/0	#DIV/0!	0/0
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	0%	/	#DIV/0!	0/0
	#DIV/0!	0/0	#DIV/0!	0/0
7. The laxative dose should be titrated daily or alternate days	#DIV/0!	0/0	#DIV/0!	0/0
OPIOID INDUCED CONSTIPATION				
8. The development of opioid induced constipation should be anticipated. A bowel regimen should be initiated at the	#DIV/0!	0/0	#DIV/0!	0/0
9. In the management of opioid induced constipation, optimised monotherapy with a stimulant laxative is essential followed by the	#DIV/0!	0/0	#DIV/0!	0/0
10. The use of opioid receptor antagonists under specialist guidance should be considered in patients whose treatment is	#DIV/0!	0/0	#DIV/0!	0/0
INTESTINAL OBSTRUCTION				
11. A stool softener should be considered in partial intestinal obstruction. Stimulant laxatives should be avoided	#DIV/0!	0/0	#DIV/0!	0/0
	#DIV/0!	0/0	#DIV/0!	0/0
12. In complete intestinal obstruction, the use of all laxatives should be avoided as even softening laxatives have some peristaltic action	0%	/	#DIV/0!	0/0

Charts

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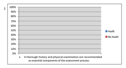

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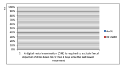

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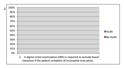

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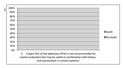

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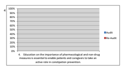

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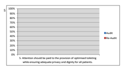

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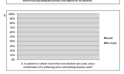

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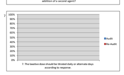

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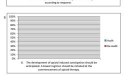

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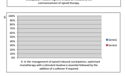

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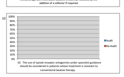

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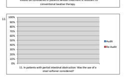

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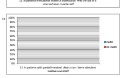

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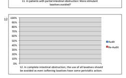

Re-Audit Data for ‘The Management of Constipation in Adult Patien

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Yes			0	
No			0	
Total			0	
Percentage			#DIV/0!	

Demographics

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ts Receiving Palliative Care' clinical audit

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Question j	Question k	Question l
Where required, was the laxative dose titrated daily or alternate days according to response?	Was a bowel regimen initiated at the commencement of opioid therapy?	Was optimisation of a stimulant laxative achieved prior to the addition of a softening laxative?

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Question m		Question n
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?	In patients with partial
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Question o	Question p
intestinal obstruction:	In patients with complete intestinal obstruction, was the use of all laxatives avoided?
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