LIABILITY
landscape

BY LINDA WILLIAMS, RN

Handling constipation and fecal impaction

As staff at most nursing facilities are aware, the occurrence of a resident having a fecal impaction is considered a sentinel event by the Centers for Medicare & Medicaid Services. It causes hardship for the resident and also for the staff, when their interventions are scrutinized by state surveyors to determine whether the event could have been avoided. Sometimes this same scrutiny and analysis find their way into a courtroom. Please take the time to review the circumstances surrounding the following situation, and make changes as appropriate at your facility.

The Situation

A 56-year-old woman was admitted to a skilled nursing facility with the following diagnoses: anemia, gastroesophageal reflux disease, Alzheimer's disease, severe multiple sclerosis, anxiety, contractures of all extremities, and reddened areas on her knees and one heel. For three years, the woman had been unable to move her upper and lower extremities voluntarily, so she had a urinary catheter and was subject to frequent fecal impactions. Before moving to the nursing facility, she had lived with her son while receiving home healthcare.

Because of the woman's frail condition, her physician wrote orders for the staff to encourage her to drink 3,000 cc of fluid each day. An enema also was to be given, up to three times per week, as needed. These and other constipation-prevention measures were incorporated into the woman's plan of care.

While at the facility, the woman's condition began to deteriorate. On her 23rd day of residence, the woman's urinary catheter began to leak, so she was transferred to the emergency room at her son's request.

The woman was admitted to the hospital with the following diagnoses: urinary tract infection with sepsis, dehydration, renal insufficiency, and high fecal impaction.

Three weeks after admission, the woman suffered acute abdominal pain, which proved to be a diverticular abscess, requiring a colostomy for relief. Three days after surgery, she seemed to be improving when she suddenly aspirated and died. Two months later, the woman's son sought legal counsel and filed a suit against the facility for his mother's wrongful death because of negligent care. His demand to settle was $3 million.

Upon examination of the woman's medical records at the nursing facility, both the plaintiff and defense attorneys discovered that the woman only had two bowel movements during her 23-day stay: One occurred two weeks after admission and the other was the day before being discharged to the hospital. In addition, the records revealed that during her last 48 hours at the facility, she consumed only 600 cc of fluids yet had a urine output of 2,000 cc. Other chart entries did not look much better, as her fluid intake during each of the previous days was less than half of the recommended 3,000 cc, and there was no dietary evaluation or notes concerning her meal intake.

Both attorneys hired expert witnesses to review the case and offer their medical opinions. The defense hired a geriatric specialist who felt that the woman's death was not causally related to the treatment she received at the nursing facility. However, the plaintiff's medical expert held an opposing view and felt there was indeed a direct link, especially related to the lack of monitoring, which led to the high fecal impaction. The parties went to mediation and agreed on a settlement of $500,000.

What Went Wrong

Undeniably, the defense's weakest point was that the staff did not pay close enough attention to the woman's bowel regularity patterns and did not intervene sooner (as directed by her plan of care) before the fecal impaction crisis struck. Medically speaking, individuals are considered to be constipated if bowel movement frequency is fewer than three times per week and/or if straining is experienced with more than 25% of bowel movements. Residents who are at risk for constipation include those with:

- limited physical activity;
- recent abdominal or perianal surgery or general anesthesia;
- inadequate diet (e.g., less than 15 grams of dietary fiber per day);
- inadequate fluid intake (e.g., less than 1,000 cc per day);
- use of drugs known to be associated with constipation (e.g., anticholinergics, tricyclic antidepressants, antiemetics, antihistamines, anti-Parkinson agents, antipsychotics/phenothiazines, antacids containing aluminum, analgesics/nonsteroidal antiinflammatory drugs [NSAIDs], barium, bismuth, diuretics, histamine-2 blockers, hypotensives, iron supplements, opioids/narcotics, and phenytoin);
- chronic constipation history;
- laxative abuse history; and/or
- comorbidities known to be associated with constipation (e.g., renal failure, electrolyte imbalances, spinal cord injury, arthritis, heart disease, diverticular disease, inflammatory bowel syndrome, colon cancer, painful lesions in the rectal or anal region, obstructing neoplasms, Parkinson's disease, amyotrophic lateral sclerosis, multiple sclerosis, myotonic dystrophy, stroke, insulin-dependent diabetes mellitus, untreated hypothyroidism, hyperparathyroidism, hypercalcemia, and symptoms of depression, dementia, psychosis, and acute confusion).

The woman in this case study had many of these risk factors, just as a significant percentage of residents that reside in nursing facilities today do. For this reason, it is important for staff to take the following precautions, as recommended by the University of Iowa in *Evidence-Based Protocol: Management of Constipation*, to minimize the occurrence of a similar crisis in their facility:

1. Identify residents at risk for constipation by using a standardized assessment tool to determine a resident's constipation risk factors. This should be done upon admission, routinely, and whenever there is a change in cognition or functional ability. "The Management of Constipation Assessment Inventory" form developed by the University of Iowa is an excellent tool. It can be found in *Evidence-Based Protocol: Management of Constipation* (contact the university's Nursing Research Department at [319] 384-4429 for more information).

2. Implement a prevention program that includes all of the following, as indicated:

- **Fluid intake.** The dietitian should perform an assessment to calculate the fluid needs of the resident. Fluid intake of at least 1.5 liters per day is recommended to avoid constipation, unless contraindicated. Water is preferred, although other fluids such as juices are beneficial. Coffee, tea, and alcohol should be avoided because of their diuretic properties.
- **Diet.** The most beneficial means to prevent constipation is a combination of insoluble and soluble fiber by increasing dietary intake of bran, fruits, and vegetables. Recommendations for dietary fiber intake vary from 25 to 30 grams per day. The dietitian should assess and recommend the amount of fiber intake for each resident at risk for constipation. Fiber supplements such as "power pudding" also may be used in combination with a high-fiber diet.
- **Physical activity.** Activity recommendations should be tailored to the individual's physical abilities and health condition. Walking 15 to 20 minutes once or twice a day (or more) as tolerated is recommended for those who are fully mobile. Ambulating at least 50 feet twice a day is recommended for individuals with limited mobility. For individuals unable to walk or who are restricted to bed rest, chair or bed exercises—such as pelvic tilt, low trunk rotation, and single leg lifts—are recommended.
- **Toileting.** Establishing a routine toileting pattern has been found to be beneficial in the management of constipation.
- **Laxatives.** Laxatives may be considered at any time if there is no bowel movement for more than three days. For chronic constipation (longer than six months), laxative use is advocated only as a supplement to the above regimen of adequate fluid intake, high-fiber diet, exercise, and toileting routine.

3. A daily bowel movement record should be kept for all dependent residents to track regularity and assess the need for interventions. All CNAs should document whether the residents they provided care for had a bowel movement. The charge nurse should look at the record each shift and initiate interventions as appropriate.

4. If the resident has not had a significant bowel movement for three days, laxative treatment is necessary, per physician order. A stepwise progression of laxative treatment is recommended. Once constipation is resolved, management should be moved to the top of the laxative pyramid. The following steps are recommended, from first to last:

- fluid, fiber, and exercise (see above);
- bulk-forming laxatives;
- stool softeners (e.g., docusate sodium);
- osmotic laxatives (e.g., lactulose or magnesium sulfate);
- stimulants (e.g., senna);
- suppository/enema (e.g., bisacodyl or sodium/potassium phosphate enema); and
- fecal impaction removal—should be performed as a last resort and only after all other interventions have failed, per physician discretion.

Finally, the resident's physician should be notified of any new patterns of constipation. This includes a previously regular resident who has a bowel movement less than three times per week and/or straining with more than 25% of bowel movements, or if a resident with chronic constipation is uncontrolled to the extent of fecal impaction removal.

By taking these necessary precautions, you have the ability to protect your residents and facility, now and into the future. ■

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