Constipation Management and Nurse Prescribing: The importance of developing a concordant approach

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The number of nurse prescribers in England is growing rapidly. There are approximately 28,750 District Nurse/Health Visitor prescribers, and 2,400 Extended Formulary Nurse Prescribers (DoH, 2004). However, the formulary for District Nurses/Health Visitors remains very limited, and the Extended Nurse Prescribers' Formulary – although expanding regularly is still criticised by many nurses as insufficient for their needs.

A formulary with items which are likely to be used by all types of nurses would be difficult to create. However, constipation preparations are one of the few therapeutic products that will arguably be prescribed independently by most nurse prescribers at some point. This is because of the common occurrence of constipation. It is estimated that 10% of the UK population are "regularly constipated" (NPC, 1999), and constipation ranks second after dyspepsia among the most frequently seen gastro-intestinal complaints in general practice (OPCS,DH and RCGP, 1995). Although not all constipation medication will be issued on prescription nevertheless a significant number are -12.8 million prescriptions for constipation were issued in 2003 (DoH, 2003). The most commonly used are therefore included within both the limited and Extended Nurse Prescribers' Formulary.

Constipation is seldom a life-threatening condition, and because of this it is easy to underestimate the impact that it can cause. However, constipation can cause significant discomfort and misery, and symptoms can frequently be left to become severe before advice is sought from health professionals (Ross, 1998). Apart from the personal cost of constipation in terms of quality of life there is a significant cost to the NHS drugs budget, with a cost of £42.9 million in 2003 (DoH, 2003). Both these factors mean that the prescribing of constipation medication should be looked at in depth by nurse prescribers.

The need to prescribe such medication frequently may signify a failure of non-prescriptive interventions as first-line solutions – such as dietary and lifestyle changes. Non-pharmacological methods should always be considered, and should be the long-term aim for most patients. However, achieving the recommended daily intake of 18 - 30 grams of fibre will not be possible for all patients, particularly those with loss of appetite, and is not recommended for patients with neurological disorders or obstructive lesions (Cummings, 1994).

Regular use of bulk forming agents may therefore be a necessity for some. Many patients requiring regular bulk forming agents will be elderly, as the incidence of constipation is significantly higher in the over-65 years population; 20% of this age group are regularly constipated. This may be linked to the fact that many older people receive regular medication for a variety of conditions (DoH, 2001), and constipation is a well-known side effect of many commonly used drugs (e.g. calcium channel blockers, opiates, tricyclic antidepressants). Constipation may therefore cause non-compliance with other drugs.

Compliance with regular therapy is known to be problematic, and it is estimated that almost 50% of older people do not take their drugs as intended (RPSGB, 1997). This raises questions about the prescribing role, and it is important for nurses to adopt a new approach to prescribing which directly involves patients in decision making about their treatment. Patients' beliefs about medicines have a huge effect on their likelihood of adherence to treatment. The role and continuing contact that nurses have with patients places them in an ideal position to interpret patient beliefs and negotiate treatment schedules accordingly. Therapeutic outcomes are more likely to be achieved if adherence to treatment can be improved. This has the potential to decrease the drugs bill and drug related problems and improve quality of life. A concordant approach to prescribing should become second nature for all nurse prescribers as this ensures that the patient is included in the decision making process. However, prior to discussing appropriate treatments with the patient it is essential to conduct an assessment to accurately determine the

diagnosis. This is essential for all patients including those with constipation who may present their diagnosis as a convincing fact (“I’m constipated nurse, can I have something for my bowels”). The diagnosis may not be as simple as the patient leads you to believe. It must be borne in mind that the frequency of bowel movements is highly variable with a wide range of “normal” and that the definition of constipation is “The passage of hard stools less frequently than the patient’s own normal pattern” (Joint Formulary Committee, 2004).

Preconceptions about constipation or treatment for constipation may lead to needless suffering. Nurses need to overcome patients’ embarrassment in discussing details of the bowel habit in order to gain an accurate picture of the state of the faeces. A useful way of determining this is to use the Bristol stool chart as a pictorial representation. The patient should also be specifically asked about the degree of ease or difficulty associated with defaecation. This should match with their typology noted from the Bristol stool chart. A history of considerable straining on defaecation combined with a description of the passage of Type1 or Type 2 stools provides a clear picture that the patient is indeed constipated and in need of a bulk forming agent that will soften and change the nature of the stools.

When assessing patients with constipation it is also important to try and determine the causative factors. This can then be used to explain how to avoid problems in the future. Patients can be alerted to the fact that dietary changes (e.g. when away on holiday) and reduced mobility are frequent causes of constipation. Raising patients’ awareness of these risk factors may encourage them to take extra fibre (e.g. high fibre breakfast cereals or bulk-forming agents) as a preventative measure. They should also be advised of the need to take extra fluids alongside increased fibre to avoid the production of bulky hard stools. Educating patients in this way about the frequently multi factorial causes of constipation will encourage them to intervene earlier with dietary changes or the use of appropriate bulk forming agents, and will decrease reliance on health professionals. Good patient literature which explores the causes and appropriate treatment of constipation should be used to emphasise education given in the consultation, such as the series of Diet

Cards which are now available through health professionals and which target children, adults and the elderly separately. In addition patients can be directed to internet sites which can provide further information in animated forms. (www.constipationadvice.co.uk/understanding-constipation/how-fybogel-works.htm).

Improving patients' knowledge about their condition and about the possible solutions will empower them and enable them to make informed choices. A practical approach to medicine taking can also be influential in helping patients adhere to a regime. If prescribers are familiar with products they can provide pragmatic advice which can make a real difference to patients. Fybogel, for example, may be tried by many patients and dismissed as unpalatable because of its texture – in fact, recent developments mean that myths about drinking immediately before setting to concrete are irrelevant. In reality Fybogel is now finely milled so it stays liquid longer, making it more palatable for patients to drink over time. If patients also understand that bulk-forming agents need to be accompanied by an increased fluid intake they are more likely to achieve good results.

Patients' beliefs about medication affect their compliance (Kemp et al, 1997) and if prescribers are able to uncover these beliefs they can provide further information and education. Patients presenting with constipation may believe that they "need" to have a daily bowel movement to be healthy. If their normal habit (without intervention) was a soft bowel movement every 2-3 days they can be encouraged to accept that this is healthy and normal for them as an individual, and they can be discouraged from taking unnecessary products to alter this.

Some patients with constipation may be resistant to taking medication because they believe that bulk forming agents can cause long-term problems. Offering patients a chance to discuss this and giving information on the mode of action of prescribed products may help to alleviate unwarranted anxieties. Education about how products work will also help patients to appreciate that a combination of medications (e.g. bulk-forming agents and stimulant laxatives)

may be useful at the onset of constipation where hard faeces are in need of being expelled before the benefits of bulk-forming agents can be realised. Bulk forming agents such as Fybogel can help maintain bowel regularity in those patients prone to regular bouts of constipation. Simply asking patients whether they have any concerns over taking the proposed medication will help to elicit patient beliefs.

Nurse prescribers faced with the assessment of patients with constipation will work within their “scope of practice” (NMC, 2002) and will not therefore prescribe outside their own competence. This competence for constipation management will obviously vary but all nurses need to be clear about their own criteria for referral onto a doctor. The features that generally require more investigation or an advanced level of diagnostic skills include the presence of:-

- Vomiting
- Blood or mucus in the stool
- Abdominal pain/tenderness
- Abdominal mass
- Alternating constipation and diarrhoea

Once nurses are confident with the diagnosis of constipation they can consider possible treatment pathways. If pharmacological interventions are required they will need to be aware of the various modes of action of the differing medications that are available to them as prescribers: - stimulant, bulk-forming, osmotic and stool softeners. Evidence for effectiveness relating to each of these can be critiqued using MeReC bulletins (NPC, 2004) or contemporary peer reviewed articles (Duncan, 2004). This professional knowledge will ensure that products they are discussing with patients are the most appropriate for their situation.

Nurses are now able to prescribe for common complaints such as constipation but this does not necessarily mean that they will do so. Nurses will look at non-pharmacological interventions where this is appropriate and

will work towards lifestyle changes as a long-term goal for most patients. A nursing approach to patients presenting with constipation should include:-

- Assessment – with interpretation of symptoms
- Education – appropriate to individual levels and eliciting patient beliefs about their condition and possible management
- Treatment – decided by the patient with
- Maintenance – including an action plan to overcome longer term recurrence of symptoms.

Nurse prescribing has given nurses an opportunity to combine their skills of patient education and reflective listening with knowledge of evidence based treatments in order to provide patients with informed choices. This concordant approach will ensure that patients receive treatments that they feel are right for them as individuals, rather than treatments that the medical profession feel are right for them.

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