Bowel care in older people

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ABSTRACT – Bowel dysfunction not only causes considerable hardship for many older people and their carers, it is also financially costly to the health service and to the individuals affected. Despite the prevalence of constipation and faecal incontinence amongst, for example, older people in institutionalised settings, both conditions are often iatrogenic and entirely preventable. One reason why these conditions are generally not well managed is that the research base is poor: there are few robust data because of methodological weaknesses in existing studies, so clinicians and care staff are left to rely on anecdote and personal experience. Secondly, the costs to the NHS involved in providing proper bowel care for the elderly would be considerable, although recent government documents have set out a specific commitment to improve standards of care in this area. In order to address some of these issues, the College has recently published a book which gathers together and assesses research on faecal incontinence and constipation, and provides informed guidance on current best practice. The contents of the publication, including comments from older people suffering from bowel dysfunction, are outlined in this article.

KEY WORDS: bowel care, bowel dysfunction, constipation, faecal incontinence

Introduction

Bowel dysfunction is a scourge of older people. Constipation is one of their commonest complaints, even though their bowel movements may be within the physiological norm. Faecal incontinence, on the other hand, remains a taboo subject and is frequently suffered in embarrassment and isolation without recourse to help. Although less prevalent than constipation, it has been reported in up to 17% of some groups of older people.[1] In institutionalised settings, for example, there is a particularly high prevalence of both constipation and faecal incontinence.[1] Different types of bowel dysfunction play a major part in the management of many conditions, ranging from the constipation associated with drug treatment for palliative malignant care to the 30% incidence of faecal incontinence associated with stroke.[2]

Bowel dysfunction is not only distressing for the individual; it also places a particular strain on carers and relationships.[1] After a stroke, the management of bowel care can be the facet of care that spouses and relatives find most difficult.

The financial cost of bowel dysfunction is also high: laxatives represent a major prescribing cost in England.[3] Studies have demonstrated that approximately one-quarter of older people in the community consume over-the-counter laxatives,[4] and one-half of older people in institutional care are prescribed laxatives.[5] Containment products are also expensive. Furthermore, the institutional care that may be required as a result of bowel dysfunction adds to the costs for both individuals and the state.

Despite the clinical and financial importance of bowel dysfunction, the attention paid to it has in the past been overshadowed by its kindred condition of urinary incontinence. Also, the meagre amount of research into the pathophysiology and management of bowel dysfunction that exists has tended to focus on the condition in younger people. However, more recently awareness of the importance of managing bowel dysfunction in providing high-quality care has improved. The issue was highlighted in the Health Advisory Service report, *Not because they are old*.[6] In 2000, the Department of Health published guidance in *Good practice in continence services*,[1] which places equal emphasis on urinary and faecal incontinence. The National Service Framework (NSF) for Older People Standard 2, 'Person-centred care,' calls for the NHS and social services to treat older people as individuals and enable them to make choices about their own care; this is to be achieved in part through the integrated provision of services for continence.[7] The NSF is supported by *The essence of care*, which provides methods for bench-marking best practice

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in managing various conditions, including bowel continence.[8]

Despite this increasing awareness of the importance of bowel dysfunction, we remain limited in our knowledge of the underlying pathophysiology, methods of treatment are still based on unsubstantiated anecdote, and we are unthinking in our provision of care. The implications of bowel dysfunction in older people are so wide-ranging that there is an urgent need to increase our understanding of the problem and improve our management.

We have begun to address some of these issues by publishing the edited proceedings of a workshop on faecal incontinence held in June 2001 at the College.[9] *Bowel care in older people: research and practice* gathers together and assesses the existing research, and provides informed guidance on current best practice. The main issues raised within the publication, including the views of older people suffering from bowel dysfunction, are summarised below.

Research

Definitions

Research into constipation and faecal incontinence has been impeded by problems over terminology and definitions. Should the conditions be defined on the basis of pathophysiological process, objective symptomatology or subjective patient experience? Until the definitions can be resolved, meaningful comparison between studies will remain difficult and the processes of meta-analysis and systematic review greatly hampered.

Pathophysiology

Although most research into the pathophysiology of bowel dysfunction has been carried out in younger subjects, knowledge of the underlying processes in older people has improved. Constipation may result from changes in colonic transit time, difficulty in defaecation and changes in anal rectal sensation. The pathophysiological processes underlying these changes are not clear but may include alterations in neural innervation, in smooth muscle activity or in neuroendocrine function. Faecal incontinence may be precipitated by local factors within the ano-rectal region, including rectal loading and ano-rectal incompetence, or by secondary factors including impaired cognitive and functional ability or loose stools.

Clinical studies

Clinical studies into the management of bowel dysfunction have not provided robust data because of methodological weaknesses. Important failings include limitations in the numbers included, the randomisation, inadequacies in controlling for confounding factors such as diet, variation in outcome measures, limitations in the methods for measuring outcomes, poor placebo control and limited time-span of studies. Given these shortcomings, it is hardly surprising that current practice remains rooted in the anecdotal beliefs and experiences of practitioners.

Clinical practice

Assessment

Bowel management provides a good test of simple clinical care: a sound history and examination remain the mainstay for initial assessment. Yet how often is this achieved in older people, who are often seen in settings not conducive to proper assessment? Constipation is the commonest cause of faecal incontinence, yet all too often no rectal examination has been carried out.

Constipation and faecal incontinence are often iatrogenic and entirely preventable. Drugs that have been prescribed frequently cause either condition. Also, there are many conditions that render older people immobile or severely reduced in functional ability and in so doing predispose them to faecal incontinence, for example stroke or Parkinson's disease. But are the necessary steps taken to prevent its onset? Faecal incontinence is often contained rather than investigated. Yet careful attention to history and examination will often reveal a treatable cause, whether it be the side effects of drugs, toxin-induced diarrhoea, the diarrhoea of autonomic neuropathy, or the first sign of underlying malignancy. Faecal incontinence in any individuals other than those with dementia or impaired conscious levels will have an underlying cause that should be amenable to treatment.

Investigations can often be kept very simple. Currently, there is a debate over the use of plain abdominal radiographs to establish the presence or absence of constipation. Although these should not be undertaken routinely, high impaction of stool does occur and is important to establish in order to ensure appropriate treatment. The possibility of underlying serious pathology, including carcinoma and colitis, should also be borne in mind. Where suspicion arises, investigation should be pursued with the judicious use of colonoscopy, barium enema and computed tomography (CT) scanning. More sophisticated tests of anorectal function are rarely required.

Management

The method of management is usually clear once the underlying cause has been established. As with many conditions in older people, however, much time, money and stress can be wasted if a clear diagnosis is not made. Laxative management remains a major challenge: the results of research to date indicate that no laxative regime is superior to any other and that the important need is to consider costs. For many older people, the maintenance of sound general health plays an essential role in maintaining normal bowel function, including adequate fluid intake, mobility and good nutrition; over-zealous use of fibre can be counterproductive.

Good management is also dependent on an appropriate environment, but the usual ward setting is far from ideal. Toilets should be close, convenient for access, warm and secure. Every effort should be made to facilitate access to the toilet. This may mean frequent visits with dependent patients which is demanding on staff time, and it is often easier and quicker to use commodes. However, this represents a challenge to the NSF Standard that patients should have a choice in their care. If the

Key Points

Bowel problems in older people are common, impair quality of life and are costly to manage

The research evidence base for appropriate management is limited and needs to be augmented

Current best practice in bowel management requires attention to the clinical condition, the environment within which care is provided and the access to clinicians with experience in its management

Older people with bowel problems emphasise the importance of privacy and dignity in their care

Audit of bowel problems provides a good opportunity to monitor the quality of care for older people

standard is to have any meaning, staffing levels and skills need to be adequate to meet the toilet needs of dependent older people. Where commodes or sani-chairs have to be used, there is now considerable research data indicating which is the most comfortable and secure equipment. At present, though, current models in regular use on wards and in residential settings leave much to be desired.

The management of bowel dysfunction in people with dementia provides a particular challenge. Bowel symptoms are common in such patients, and considerable insight and experience are required to understand the underlying reasons for the specific problem. It may relate to neurological disorders including agnosia, inattention and dyspraxia; other underlying factors include disorientation, depression, fear, curiosity, manipulation and embarrassment. An understanding of the various causes is needed to develop a management plan for effective control, but all too often poor attention to bowel function precipitates further symptoms caused by anxiety and agitation.

Service provision

Problems of constipation and faecal incontinence should be actively sought out in high-risk groups of older people, because faecal incontinence in particular is often suffered in silence. Such groups should have ready access to professionals with expertise in the proper assessment and management of both constipation and faecal incontinence. Those caring for older people should also have access to information and training in the basic management of bowel function.

The patient's view

The most important comment that emerged from interviews with older people suffering from constipation and/or faecal incontinence was their desire for dignity. Issues highlighted included their wish to use a toilet rather than a commode whenever possible, that facilities should be clean, that there should be timely response to calls for assistance, and that care assistants should have proper training and supervision to ensure appropriate care. People with faecal incontinence are bound to have accidents and they should not be blamed for doing so.

Many older people said that professionals gave them the impression that there was nothing that could be done about their condition and that it was the individual's fault. Regimented unthinking responses to bowel care were very much in evidence. Support and services tended not to be available to them unless someone 'kicked up a fuss'. Such views highlight the urgent necessity for the health service to live up to its declared commitment to provide the appropriate facilities, staffing levels, training and information about bowel dysfunction.

Quality of care

Although not a life-and-death condition, bowel care represents a good mechanism for assessing the quality of care provided for older people. With the introduction of the Government's quality agenda,[10] there is now a need to identify mechanisms which will signal the quality of care provided. It is a good measure of the quality of the environment in which care is provided.

The Department of Health guidance in *Good practice in continence services*[1] provides a useful basis on which to plan. The recent NSF for Older People Standard 2, 'Person-centred care',[7] requires managers and professionals to listen to older people, to respect their dignity and privacy, and to support their carers. In few other conditions is this so important as in bowel care. Yet every ward in the country still provides an environment which is problematic for a person with bowel problems. How many people would wish to defaecate in the company or three to five other people separated only by curtain, often inadequately drawn? Although there are clearly logistical problems to resolve in meeting the needs of patients with bowel problems, services have tended to be planned for the convenience of professionals and efficiency of hospitals rather for than the well-being of patients.

Clinical indicators of good care in bowel management are currently being developed and a national audit is proposed for the near future.[11] Effective audit of the management of bowel care would provide a test of our clinical competence and of how well we really listen to and respect the privacy and dignity of older people.

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