COMMONWEALTH of VIRGINIA

Nelson Smith
Commissioner

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

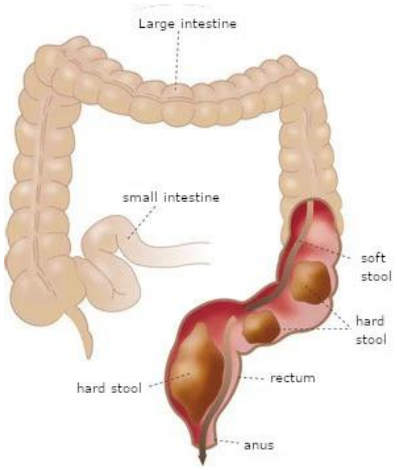
Office of Integrated Health
Health & Safety Alert/Information

Part 2 - Constipation and Individuals with Intellectual and Developmental Disabilities Health & Safety Alert

Introduction

Constipation is a condition in which an individual has difficulty starting or completing a bowel movement (defecation). Constipation is typically described as having fewer than three bowel movements a week (9) (24), but may include any or all of the following:

- Straining during defecation.
- Lumpy, hard or marble-like stools.
- Painful defecation.
- Two or less bowel movements per week.
- The sensation of incomplete defecation of stool.
- The sensation of anal blockage, and/or difficulty passing stool which persists for several weeks or longer (26)(33).



Constipation can significantly affect an individual's quality of life and, if left untreated, can lead to numerous other health problems, including death. This is especially true among individuals with intellectual and developmental disabilities (IDD) who have a much higher risk of complications due to constipation than the average person. Greater than 50% of the IDD population experiences some form of constipation (26).

How individuals with intellectual and developmental disabilities are impacted by constipation including the prevalence, cause, risk, diagnosis, treatment, complications, and care considerations will be the focus of this two-part health & safety alert.

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Treatments for Chronic Constipation

Managing chronic constipation in individuals with IDD may involve the layering of treatments to include:

- Addressing the underlying cause.
- Implementing lifestyle changes.
- Administering medications, etc. (12).

The natural, non-pharmaceutical, defense for constipation includes:

- The increase of fiber in the diet by adding more fruits and vegetables.
- Adding a daily fiber supplement.
- Increasing intake of non-caffeinated beverages.
- And increasing physical activity and/or repositioning (10) (33) (9).

A primary care provider (PCP) might prescribe supplemental fiber once or twice daily which can be dissolved into water or another non-caffeinated beverage to increase bulk in the stool. The recommended daily intake of fiber is between 25 - 35 grams for adults, depending on the gender and age of the individual (30) (33).

Fiber supplements:

- Include psyllium (Metamucil, Konsyl), calcium polycarbophil (FiberCon) and methylcellulose fiber (Citrucel).
- Is most effective in relieving mild to moderate constipation.
- Delay gastric emptying and depress appetite.
- Require encouragement to increase water and/or non-caffeinated beverage intake to be effective (33).

With the addition of fiber and lifestyle changes a PCP may also add medications such as laxatives and stool softeners to reduce constipation which is especially true in the IDD population (1).

A PCP may prescribe laxatives to help an individual to produce a stool, or to completely empty the bowel when defecating. An order from the individual's PCP or healthcare specialist is required to administer over the counter (OTC) laxatives and stool softeners.

The goal of a laxative is to:

1) To increase the frequency of bowel movements.
2) Make bowel movements easier and less painful, so the individual can defecate.

The following are some of the most commonly used types of laxatives (10) (24).

- **Stimulants** increase the sensation to defecate. Some common stimulants include Correctol, bisacodyl (Ducodyl), Dulcolax and senna-sennosides oral (Senokot).
- **Osmotic laxatives** help fluids move through the colon. Examples include oral magnesium hydroxide (Phillips Milk of Magnesia), magnesium citrate, lactulose (Kristalose), polyethylene glycol (Miralax).
- **Lubricants** such as mineral oil enable stool to move through the colon more easily.
- **Stool softeners** such as docusate sodium (Colace) and docusate calcium (Surfak) moisten the stool by drawing water from the large intestines.
- **Enemas and suppositories** such as sodium phosphate (Fleet), soapsuds or tap water enemas can be useful to soften stool in the colon to produce a bowel movement. Glycerin or bisacodyl suppositories also soften stool in the colon to ease passage of stool through the anus.

Over time the bowel becomes dependent on these medications to produce stool. The muscle strength and tone in the colon can also be reduced with the overuse of stimulant laxatives resulting in laxative dependency making it even harder for the individual to open the bowel to defecate (6).

A systematic review and meta-analysis of randomized controlled trials on the use of **probiotics** for chronic constipation in the general public showed 59% had improvement in stool frequency, and better bowel evacuation. The study reported evidence for the use of probiotics which include *Bifidobacterium lactis* for stool frequency, and *Bacillus coagulans* Unique IS2 for abdominal pain and reducing painful defecations (31) (13).

A high-fiber diet, increased water intake, and exercise are the most common and affordable initial treatments for constipation which have very few negative side effects (12). However, according to some clinical studies only about half (50%) of people using laxatives felt they were entirely effective in producing a complete bowel movement (33).

One type of laxative may not be sufficient for an individual. The PCP may need to adjust dosages and/or add a different type of laxative to get the needed results for each individual. The same type of treatment will not work for everyone (9). A multi-faceted approach using multiple layers of treatments usually work best (10) and all treatments should be individualized.

If the individual's constipation symptoms are still not adequately relieved the PCP may recommend other medications or surgical interventions (12) (33) including:

Alternatives might include:

- **Secretagogues**: medications that increase the secretion of water into the intestine to assist with the movement of stool. Examples of secretagogues are Lubiprostone (Amitiza), linaclotide (Linzess), and plecanatide (Trulance).
- **Serotoninergic agonists**: newer constipation medications still in clinical trials which increase muscle contractions in the colon to produce a stool specifically to help individuals who struggle with anal muscle weakness (12) (33).
- **Surgical interventions:** such as an ileostomy or a colorectal resection. However, these are usually not recommended until all other treatments have failed to improve the individual's chronic constipation symptoms (12) (33) (9).

Pain and Discomfort

Pain and discomfort experienced during defecation by individuals with IDD who have difficulty communicating their symptoms to caregivers, and/or cannot verbalize using words, may express themselves with behavior changes, emotional outbursts, self-injurious harm, or aggression toward themselves and others (26) (14).

- Individuals may not be able to report accurately on their own toileting habits when asked. An individual might state they are having regular bowel movements when actually they are not, which is true for the general population and the IDD population alike (9) (6).
- When an individual with IDD has complaints about common signs or symptoms of constipation it should be reported to the individual's PCP and assessed right away (9) (6).
- Individuals with IDD experience more serious complications due to constipation than the general population (19) (6).
- While most individuals with IDD may not be able to tolerate the prep for a colonoscopy, which is the gold standard for exploring abnormalities in the colon, including cancer, a Computed Tomography (CT) scan may be an acceptable alternative (8).

Complications of Chronic Constipation

Poor coordination of pelvic floor muscles, impaired rectal sensation, along with reduced intestinal movement of stool through the GI tract can result in chronic constipation and several health complications (12) (9) (24).

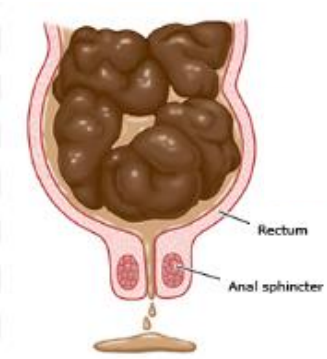
Some complication of constipation which can result from chronic constipation are:

- Hemorrhoids - Swollen tissues around the anus.
- Rectal bleeding - Bright red blood in the commode after defecation.
- Anal fissures - Tears in skin around the anus.
- Diverticulitis - Occurs when pouches in the large intestine become inflamed or infected.
- Rectal prolapse - The colon detaches from inside the body and pushes out of the rectum.
- Fecal impaction - Hard, dry stool is stuck in the body and unable to be expelled naturally.
- Bowel obstruction – Hard stool blocks the intestinal tract sometimes requiring surgery to correct.
- Bowel incontinence - Involuntary loss of stool or gas.
- Bowel perforation - A hole in the wall of the small intestine or colon (10) (4) (24).

Fecal Impaction

Fecal (stool) impaction is a result of severe constipation which occurs when hard stool backs up in the colon. The inability to pass the collection of hard stool in the rectum results in a large bowel obstruction (3).

Signs and symptoms of a fecal impaction include the following:



- Chronic constipation.
- Rectal and abdominal discomfort.
- Loss of appetite.
- Nausea and vomiting of fecal matter.
- Paradoxical diarrhea, which is liquid stool leaking around the fecal mass, imitating incontinence.
- Urinary frequency and/or urinary overflow incontinence.
- Abdominal distention and tenderness.
- Rectal bleeding.
- Fever (3).

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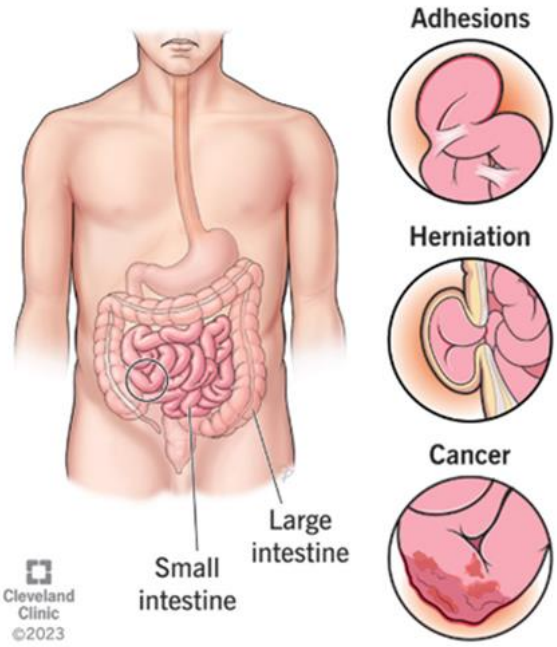
Bowel Obstruction

A bowel blockage or obstruction occurs when something prevents the stool in the small or large intestine from passing through the digestive tract and out of the body. An obstruction can be caused both inside and outside the intestinal tract (5) (17).



Swelling tissue, adhesions, a tumor, or stool can block the inside passage of the bowel. Herniation, or internal organs can pinch or twist a section of intestine compressing it from the outside to cause a blockage (5) (17).

A bowel obstruction can be total or a partial blockage, depending on whether any intestinal contents can pass through the bowel (17).

In the small intestine, the most common causes of bowel obstruction are adhesions, hernia, and tumors. In the large intestine, the most common causes of bowel obstruction are colorectal cancer, twisting of the colon, and diverticulitis (5).

Signs and Symptoms of a Bowel Obstruction

- Nausea and vomiting of fecal matter.
- No flatus passing through the rectum.
- Abdominal pain, which can be either vague and mild, or sharp and severe, depending on the cause of the obstruction.
- Constipation at the time of obstruction, and intermittent bouts of constipation that have occurred several months beforehand.
- A “tight” or firm and/or bloated abdomen, sometimes with abdominal tenderness.
- Rapid pulse and rapid breathing during episodes of cramps.
- Diarrhea resulting from liquid stool leaking around a partial bowel obstruction.
- Cramping with abdominal pain, generally coming in intense waves that strike at intervals of five to 15 minutes. Pain may occur in the navel area, or between the

navel and the rib cage. Pain which becomes constant may be a symptom of bowel strangulation.

- If a colon tumor is the cause, a history of rectal bleeding (such as streaks of blood on the stool) (25) (8).

Large bowel obstruction is an emergency situation that **can be fatal, in cases of acute complete obstruction and/or delayed diagnosis or treatment** (25).

- ★ **If an individual has *any* signs or symptoms of a bowel obstruction, take the individual to the ER immediately.**

If the bowel obstruction leads to vomiting, this can also result in aspiration of fecal material into the lungs, which can lead to pneumonia or death (25).

The potential complications of a bowel obstruction include:

- Electrolyte imbalances.
- Dehydration.
- Jaundice.
- Intestinal perforation.
- Tissue necrosis.
- Infection.
- Septicemia.
- Death (25).

ER Advocacy for Bowel Obstruction

Accompany an individual with IDD to the ER to advocate whenever possible, even when the individual is transported by ambulance.

Communicate the individual's baseline functioning (their typical normal functioning).

Communicate any recent changes observed, when the recent changes started, what the progression of the changes have been, and what you know about the change in the individual's condition, as best as you can.

Try to be as specific as possible when describing the individual's change in condition (sample below):

"Bobbie has severe and profound IDD."

"He is completely dependent on caregivers for his ADL's."

"He is incontinent of bladder and bowel."

"He wears adult briefs and a condom catheter,"

"Bobbie has not had a bowel movement for 3-4 days."

"Bobbie has had increased behaviors over the last week, which may be due to abdominal pain."

"Bobbie was crying loudly and seemed to be in pain on the way to the ER."

IF THE INDIVIDUAL HAS A HISTORY OF SEPSIS OR BOWEL OBSTRUCTION, TELL ER STAFF IMMEDIATELY.

Emergency Room (ER) Advocacy Card

The ER Advocacy Card is business card sized, 3" x 2", which can be carried in a wallet for easy access. This tool was designed to help caregivers of individuals with IDD who may not be able to advocate for themselves while in the ER due to communication issues or feeling unwell. Caregivers can request the minimum diagnostic tests and/or assessment be completed in order to reduce the risk of preventable death associated with the Fatal 7.

Diagnostic testing and/or assessment results provide objective evidence which will either verify or rule-out a particular suspected medical condition so the individual with IDD can receive the care they need while at the hospital.

Emergency Room Advocacy Card DBHDS

Condition	Diagnostic Test or CA
Aspiration	Chest X-ray, Vital Signs
Constipation	Abdominal X-ray, CA
Dehydration	CBC, CA, Vital Signs
Falls	X-ray, CT, MRI, CA
Pressure Injury	CA
Seizures	EEG
Sepsis	CBC, CA, Vital Signs, Lactic Acid Levels
Urinary Tract Infection (UTI)	Urinalysis, CBC, CA

On the front of the card there is a list of conditions on the right. On the left is a list of diagnostic tests and medical abbreviations which should be completed to rule-out the condition while in the ER with an individual.

On the back of the card are definitions explaining the medical abbreviations on the front. A list of normal vital signs for adults on the right and at the bottom a section on "*Who to seek help from while in the hospital*" for advocacy assistance.

Emergency Room Advocacy Card DBHDS

Definitions		Normal Vital Signs
CBC	Complete Blood Count - Lab work	Temp: 98.6°F
CA	Clinical Assessment	Pulse: 60-100
CT	Computerized Tomography Scan	Resp: 12-20
MRI	Magnetic Resonance Imaging	B/P: 120/80
EEG	Electroencephalogram	O2: 98% - 100%

Who to seek help from in the hospital -	
The Patient Advocate	The Hospital Social Worker
The Charge Nurse	The Medical Director

Typically standard ER discharge instructions recommend a follow-up appointment with the individual's PCP within two weeks of discharge. A follow-up appointment is a good idea for continued monitoring of the medical condition which brought the individual to the ER initially. Also, to up-date the PCP on changes to the individual's condition, medication changes, or recommended treatments prescribed in the ER.

The Office of Integrated Health Supports Network ER Advocacy card is available for download and printing on the DBHDS website/Integrated Health under the Educational Resources/Advocacy button: https://dbhds.virginia.gov/wp-content/uploads/2025/02/ER-Advocacy-Card.pdf

Questions or concerns regarding the ER Advocacy Card should be directed to the OIHSN Registered Nurse Care Consultant team at communitynursing@dbhds.virginia.gov.

Bowel Management Orders/Protocols

Individuals with IDD who suffer from chronic constipation may benefit from an individualized bowel management protocol. A daily recording of an individual's bowel habits may assist in avoiding serious complications due to chronic constipation even if only used for a temporary period of time (19) (6).

A person-centered individualized bowel management protocol should be based on the individual's bowel history to include:

- Signs and symptoms the individual experiences indicating constipation, and red-flag symptoms of constipation complications.
- Lifestyle considerations, such as how many hours of sleep the individual gets within 24 hours, their diet and exercise patterns, and any restrictions to activities due to bowel problems.
- Other factors, such as mobility and sensory problems, communication issues, degree of independence in toilet use and attitude to bowel management.
- Medications taken for constipation and method of constipation management.
- Other diagnoses, such as diabetes, thyroid or psychiatric problems (6).

Information to consider when developing an individualize bowel management protocol would include:

- Current constipation status.
- Current medication and medical history.

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- Monitoring of bowel movement frequency, consistency, and volume based on the Bristol Stool Chart.
- Diet, weight and whether the individual is on enteral tube feeding.
- Management method and laxative regime to include current laxative schedule and/or specific instructions regarding when to administer PRN laxatives.
- Utilization of a bowel diary to record stool frequency and consistency.
- Repositioning requirements to include what amount of time daily should be spent standing or engaging in physical activity.
- Instructions on food and fluid intake.
- Clearly defined description of the individual's symptoms which should prompt a caregiver to contact the individual's PCP for assistance.
- Specific directions on what to do next if the PCP cannot be reached when constipation or red flag complication events occur (19) (6). Clearly defined description of the individual's symptoms which should prompt assessment in an Emergency Room or Urgent Care Center.

Example of a bowel dairy which uses the Bristol Stool Chart:

Week	Time	Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7	How much? S = small M = medium L = large
		Separate hard lumps, like nuts (hard to pass)	Sausage-shaped but lumpy	Like a sausage but with cracks on its surface	Like a sausage or snake – smooth and soft	Soft blobs with clear-cut edges (passed easily)	Fluffy pieces with ragged edges – a mushy stool	Watery, no solid pieces – entirely liquid	
Monday									
Tuesday									
Wednesday									
Thursday									
Friday									
Saturday									
Sunday									

If a PCP writes an order for an "as needed" (PRN) laxative or stool softener to be given for constipation to an individual, the order should contain specific instructions indicating when to give the PRN medication, the exact amount to be given, and what to do if the medication is not effective in producing defecation within a designated time frame.

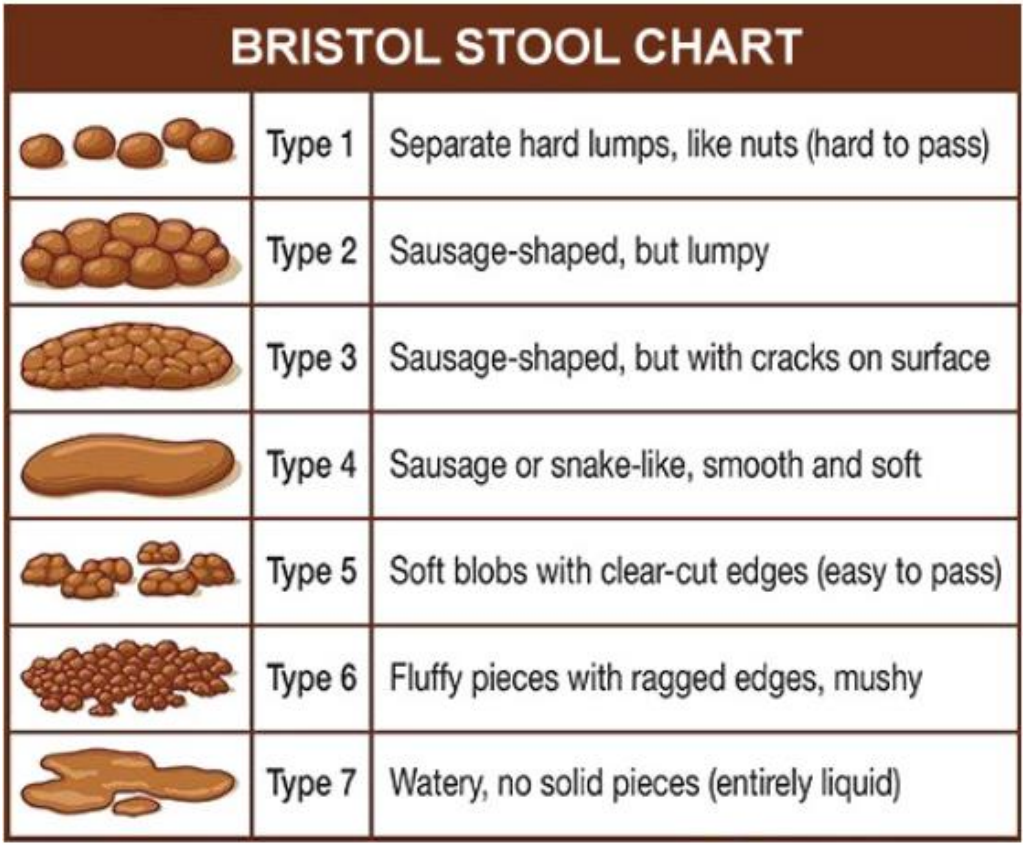
An example: If the order is for a laxative, a time frame should be specified for the desired result (defecation). The instructions should include when to repeat the laxative if defecation does not occur after the administration of the 1st dose, how many times to repeat the administration of the laxative, or not, and the designated time frame between dosages. Always contact the prescribing physician if the desired effect is not achieved within the specified time frame (6).

Care Considerations for Chronic Constipation

- Training and education for all caregivers on the topic of constipation has been shown to reduce the occurrences of constipation complications in the IDD population (19).
- Caregivers should assist with training and education on basic toileting, and/or assistance with toilet-squat-assist devices, if needed (11).
- Toilet squat assist devices are stools to elevate the feet, so the knees are above the hips which puts the person into a squat-like position. Squatting is the most effective position for a person to defecate. Squatting stools reduce straining and can make it easier for an individual to defecate, especially if the individual is constipated (11).

- If an individual has a person-centered bowel management protocol it is best practice for all caregivers to be educated and found competent to deliver the PCPs care instructions if any skills are involved (19) (6).
- It is also helpful to carve out a time to review the protocol so all caregivers have a chance to ask questions to clarify any confusion or concerns they may have.
- Individualized bowel management protocols should be written so a layperson does not have difficulty understanding them and they should be easily accessible to all caregivers at all times for reference (19) (6).
- It is best practice to follow the U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (HHS) Dietary Guidelines of Americans 2020 – 2025 when planning meals (21).
- Always consult with a dietitian and/or nutritionist prior to adjusting an individual's diet to include an increase in high-fiber foods to address constipation issues (21).
- Encourage individuals to drink plenty of non-caffeinated fluids. Dehydration is directly linked to constipation.

- USDA recommendations for daily fluids for adult males is 15.5 8-ounce cups or 3.7 liters.
- USDA recommendations for daily fluids for adult females is: 11.5 8-ounce cups or 2.7 liters (28).
- Encourage individuals to stay as active as possible and plan activities that will promote physical exercise or movement. Physical activity (including standing) other movements promotes the passage of stool through the digestive tract (24).
- Assist individuals to establish a schedule for bowel movements. Eating stimulates the bowels to move. The best time to toilet after a meal is about 20 to 40 minutes (22).
- Using an established framework of reference for bowel movements like the Bristol Stool Scale helps caregivers to consistently document characteristics of an individual defecation (26).
- Allow adequate time for individuals to use the bathroom. If an individual is eating three nutritionally balanced meals a day, they should be evacuating a similar amount of stool from the body daily or at least every other day (20).
- Encourage proper positioning. (See the resources section for more information on positioning) (20).
- Non-ambulatory individuals who spend the majority of time sitting should be assessed by a Physical Therapist (PT) for the use of a stander (prone or supine) to promote proper bowel function (29).
- Administer laxatives as prescribed by the individual's PCP or specialist healthcare professional. All caregivers should be educated regarding PRN laxative requirements for an individuals constipation.
- It is best practice to track bowel movement frequency, consistency and volume on a bowel chart when an individual has episodes of chronic constipation to avoid an increase of complications (6).
- Consult an OT or PT to determine if an individual would benefit from the use of a squat assist toileting foot stool. Toileting footstools elevate the feet to adjust the body into a squatting position which helps evacuate the rectum more naturally (7).



Resources

Download a Stool Diary (National Institute of Diabetes and Digestive and Kidney Diseases, n.d.): https://www.niddk.nih.gov/-/media/Files/Weight-Management/Stool_Diary_508.pdf

Download a Bristol Stool Chart (Lewis & Heaton, 1997) to use as a reference here: https://www.nice.org.uk/guidance/cg99/resources/cg99-constipation-in-children-and-young-people-bristol-stool-chart-2

Check out Johns Hopkins' (Lee & Johns Hopkins Medicine, 2019), "Constipation: Causes and Prevention Tips" article here: https://www.hopkinsmedicine.org/health/conditions-and-diseases/constipation-causes-and-prevention-tips

U.S. Department of Agriculture (USDA) and the Department of Health and Human Services (HHS) Dietary Guidelines of Americans 2020 – 2025: https://www.dietaryguidelines.gov/sites/default/files/2020-12/Dietary_Guidelines_for_Americans_2020-2025.pdf

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To the best of the OIHSN Nursing Team's knowledge the information contained within this alert is current and accurate. If the reader discovers any broken or inactive hyperlinks, typographical errors, or out-of-date content please send email to communitynursing@dbhds.virginia.gov to include the title of the Health & Safety alert with specifics details of concern.

Part 2: Constipation Quiz/Evaluation

Name: _____ Date: _____

Email Address: _____

Quiz:

1. Constipation is typically described as…
    a. Two or less bowel movements per week and difficulty starting or completing a bowel movement.
    b. Straining during defecation and the sensation of incomplete defecation of stool.
    c. Having fewer than five bowel movements in a month and being dehydrated.
    d. A & B.
2. What percentage of individual's with IDD experience some form of constipation?
    a. Less than 10%
    b. Greater than 50%
    c. Less than 50%
    d. Greater than 25%
3. Managing chronic constipation in individuals with IDD may involve the layering of treatments to include:
    a. Addressing the underlying cause.
    b. Implementing lifestyle changes.
    c. Administering medications.
    d. All of the Above.
4. The natural, non-pharmaceutical, defense for constipation includes:
    a. Adding a daily fiber supplement.
    b. Eating large amounts of processed foods.
    c. Drinking only caffeinated beverages.
    d. Sitting around all day.
5. A multilayered approach to constipation might include:
    a. Repositioning or increased activity levels.
    b. A daily fiber supplement plus increased intake of non-caffeinated beverages.
    c. A stool softener and a laxative.
    d. A rectal suppository if no bowel movement in 24 hours.
    e. All of the above.
6. The down side to using laxatives to produce a bowel movement is:
    a. There are no negatives to using laxatives.
    b. They cause dehydration in the body.
    c. Over time the bowel becomes dependent on the laxative to produce stool.
    d. The use of laxatives can cause bowel obstructions.
7. Stool softeners assist an individual in producing a bowel movement by:
    a. Increasing the sensation to defecate.
    b. Moistening the stool by drawing water from the large intestines.
    c. Helps fluids move through the colon.
    d. Removes moisture from the stool.
8. Common complications as a result of chronic constipation include:
    a. Hemorrhoids.
    b. Anal fissures
    c. Fecal impaction
    d. Bowel obstruction
    e. Rectal bleeding
    f. Diverticulitis
    g. Rectal prolapse
    h. All the Above

Part 2: Constipation Quiz/Evaluation

Name: _____ Date: _____

Email Address: _____

9. The signs and symptoms of fecal impaction include:
    a. Increased appetite, and edema in the feet and hands.
    b. Sweating, increased thirst, and incontinence.
    c. Chronic constipation, abdominal discomfort, and paradoxical diarrhea.
    d. Increased pulse, high blood pressure, and hyperglycemia.
10. The inside passage of the bowel can be blocked by:
    a. Swelling tissue. c. Adhesions.
    b. Stool. d. All of the Above.
11. In the large intestine, what is the most common cause of bowel obstruction?
    a. Hemorrhoids. c. Twisting of the colon.
    b. Anal fissures. d. Rectal bleeding.
12. What are the signs and symptoms of bowel obstruction?
    a. Nausea and vomiting of fecal matter. c. Abdominal pain.
    b. No flatus passing through the rectum. d. All of the Above.
13. A large bowel obstruction:
    a. Is a medical emergency c. Can ultimately lead to death.
    b. Can lead to septicemia. d. All of the Above.
14. A person-centered individualized bowel management protocol should include:
    a. Management method and laxative regime to include current laxative schedule and/or specific instructions regarding when to administer PRN laxatives.
    b. Repositioning requirements to include what amount of time daily should be spent standing or engaging in physical activity.
    c. Monitoring of bowel movement frequency, consistency, and volume based on the Bristol Stool Chart.
    d. All of the Above.
15. A toilet squat assist device is:
    a. A foot-stool which allows an individual to get into a squat position while sitting on the commode.
    b. Very low toilet which allow an individual to squat while using the commode.
    c. A mechanical device which forces an individual into a squat to defecate.
    d. None of the Above.

Evaluation:

1. Was the information presented in this Health & Safety Alert helpful?
    a. Yes b. No
2. Will you use this Health & Safety Alert information to train other staff?
    a. Yes b. No
3. Did you attend the Regional Nursing Meeting to obtain the Continuing Nursing Education (CNE) unit for this Health & Safety Alert?
    a. Yes c. Yes, but I would have attended the meeting regardless
    b. No d. No, I am not a nurse
4. Other Comments:

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