NGN NCLEX 2026 · GASTROINTESTINAL · BOWEL ELIMINATION

Constipation vs *Diarrhea*

A side-by-side clinical reference: pathophysiology, priority nursing care, pharmacology, patient teaching, and complete diet/food lists. Built for the NGN test plan and bedside review.

SYSTEM: GI | CLUSTER: ELIMINATION | PRIORITY: FLUID + ELECTROLYTE

NGN FOCUS: CLINICAL JUDGMENT

§ **Source disclosure:** This topic is not covered in your uploaded personal notes. Content is synthesized from standard NCLEX 2026 references: *Saunders Comprehensive Review for the NCLEX-RN*, *ATI RN Adult Medical-Surgical Nursing*, *Lippincott Pharmacology Made Incredibly Easy*, and current AGA (American Gastroenterological Association) and ACG (American College of Gastroenterology) practice guidelines.

01 DEFINITION · OVERVIEW

What you're looking at

Both are alterations in bowel elimination, but they sit on opposite ends of the spectrum. Knowing the baseline definition shapes every priority that follows.

CONSTIPATION Slow · Hard · Infrequent

- Fewer than **3 bowel movements per week**
- Hard, dry, difficult-to-pass stool (Bristol stool scale type 1–2)
- Straining, sense of incomplete evacuation, abdominal fullness
- Causes: low fiber, dehydration, immobility, opioids, anticholinergics, iron, pregnancy, hypothyroidism, IBS-C

DIARRHEA Fast · Loose · Frequent

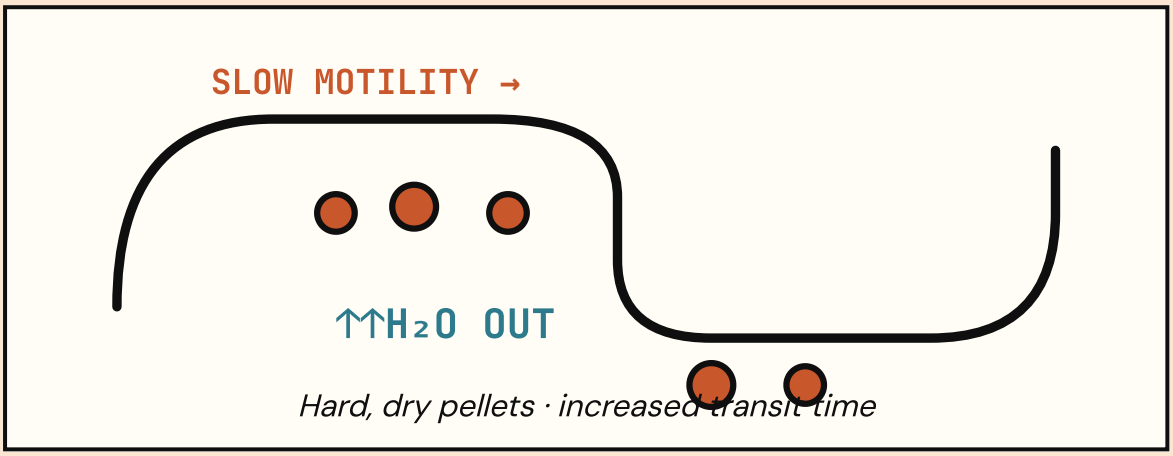
- ≥ **3 loose / watery stools per day** (Bristol stool scale type 6–7)
- Acute < 14 days · Persistent 14–30 days · Chronic > 30 days
- Urgency, cramping, possible fever, possible blood/mucus
- Causes: infection (C. diff, viral, Salmonella), tube feedings, laxative overuse, IBD, IBS-D, antibiotics, malabsorption

02 PATHOPHYSIOLOGY · SIMPLIFIED

The mechanism, step by step

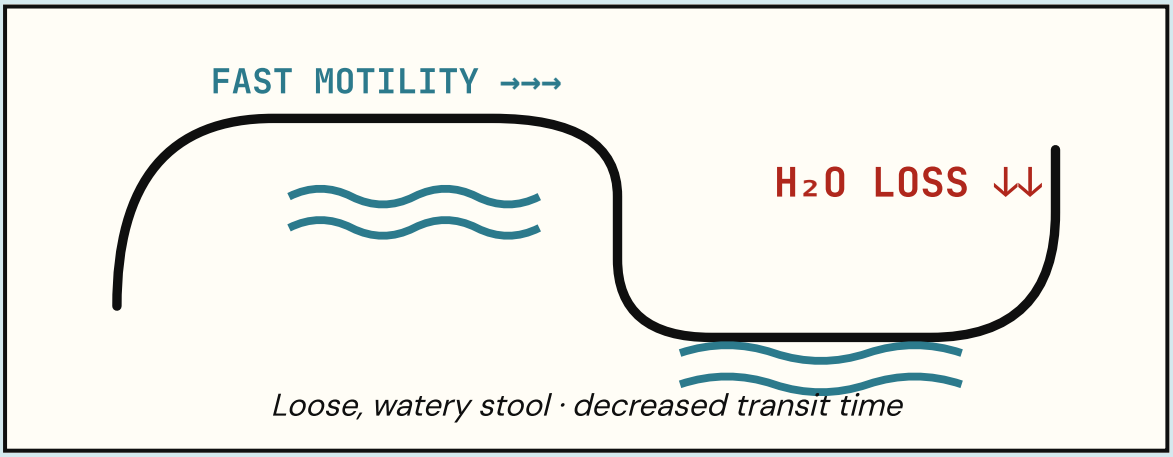
It's a balance problem. The colon has one job: pull water out of stool and move it along. When that balance breaks, you get one extreme or the other.

Constipation → Too Much Water Reabsorbed



Slow peristalsis → Stool sits in colon longer → ↑ Water absorption →
Hard, dry stool → Difficult passage / straining

Diarrhea → Not Enough Water Reabsorbed



Trigger (infection, irritant, osmotic load) → ↑ Peristalsis →
Stool moves too fast → ↓ Water absorption →
Watery stool + fluid/electrolyte loss

03 SIGNS · SYMPTOMS · RED FLAGS

What you'll assess at the bedside

The top half is what you expect. The bottom half — in red — is what tells you to escalate. NGN items routinely test the difference.

CATEGORY	CONSTIPATION	DIARRHEA
GI / STOOL		
	Hard, dry, pellet-like; straining; < 3 BMs/week	Loose, watery, ≥ 3/day; urgency; possible mucus
ABDOMEN		
	Distended, firm, tender; hypoactive/absent bowel sounds; palpable mass (LLQ)	Hyperactive bowel sounds; cramping; flatulence; tender
VITAL SIGNS		
	Usually normal; ↑ BP with straining (Valsalva risk)	↑ HR, ↓ BP if volume-depleted; possible fever
FLUID / SKIN		
	Generally well-hydrated; possible dry mucosa if cause is dehydration	Dry mucosa, poor turgor, ↓ urine output, sunken eyes
LABS		
	Usually normal; may see ↑ BUN if dehydrated cause	↓ K^+, ↓ Na^+, ↓ HCO_3^- (metabolic acidosis), ↑ BUN/Cr
RED FLAGS		
	STOP No BM > 3 days + vomiting · ribbon-like stool · rectal bleeding · severe pain · suspected impaction or **obstruction**	

STOP Bloody / black stool · fever > 101.4°F · severe dehydration · K^+ < 3.5 · suspected **C. difficile** · > 6 stools/day

04 PRIORITY NURSING INTERVENTIONS · ABC FRAMEWORK

What you do first, second, third

Diarrhea is the higher-acuity priority on most NGN items — fluid + electrolyte loss = hemodynamic risk. Constipation becomes priority when impaction or obstruction is suspected.

A — Airway

- Generally intact in both
- Watch aspiration risk in severe vomiting (obstruction)

B — Breathing

- Kussmaul respirations = metabolic acidosis from prolonged diarrhea
- Splinting from abdominal distention in obstruction

C — Circulation

- **#1 priority in diarrhea** — IV fluids, orthostatic VS
- Replace K^+ (NEVER IV push)
- Monitor for hypovolemic shock

S — Safety

- Skin breakdown from frequent stools
- Fall risk from urgency/orthostasis
- Contact precautions for C. diff (soap & water — NOT alcohol gel)

Constipation · Priority Actions

1. **Assess** bowel sounds, last BM, abdominal distention, rule out **impaction** (digital exam if ordered) and **obstruction** before any laxative
2. **Increase fluid** intake to 2–3 L/day (unless contraindicated by HF/CKD)
3. **Increase fiber** gradually — 25–35 g/day; pair with fluids
4. **Encourage ambulation** — movement stimulates peristalsis
5. **Establish routine** — toileting 30 min after meals (gastrocolic reflex)
6. **Positioning** — feet on stool, knees above hips (squat angle)
7. **Administer laxatives** in correct order: bulk → osmotic → stimulant → suppository → enema
8. **Hold straining** in cardiac patients (Valsalva = bradycardia, ↑ ICP risk)

Diarrhea · Priority Actions

1. **Assess** hydration: VS, orthostatic BP, urine output, skin turgor, mucous membranes, LOC
2. **IV fluids first** — isotonic (0.9% NS or LR) for moderate-severe dehydration

3. **Replace electrolytes** — monitor K^+, Na^+, HCO_3^-; oral rehydration solution if tolerated
4. **Stool culture** before antidiarrheals if infection suspected
5. **Contact precautions + soap-and-water handwashing** if C. diff suspected (alcohol gel does NOT kill spores)
6. **Protect perianal skin** — clean gently, barrier cream, avoid rubbing
7. **Strict I&O** — weigh diapers, daily weights, count stools
8. **HOLD antidiarrheals** in infectious / inflammatory diarrhea (traps toxin)

05 PHARMACOLOGY · COMPARISON

The drugs that move (or stop) the bowel

Knowing the mechanism class lets you predict onset, side effects, and contraindications without memorizing every drug name.

CLASS	DRUGS (EXAMPLES)	MECHANISM	KEY SIDE EFFECTS	NURSING PRIORITY
Bulk-forming FIRST-LINE	`Psyllium` (Metamucil) `Methylcellulose` (Citrucel)	Absorbs water → softens & enlarges stool → stimulates peristalsis	Bloating, gas, esophageal obstruction if dry	**Always give with full glass of water.** Onset 12–72 hr. Safest in pregnancy.
Osmotic	`Polyethylene glycol` (MiraLAX) `Lactulose` `Magnesium hydroxide` (MOM)	Pulls water into the bowel lumen via osmosis	Dehydration, electrolyte imbalance, cramping	Lactulose lowers ammonia in **hepatic encephalopathy** — goal 2–3 soft stools/day. Avoid Mg in renal failure.
Stool softener	`Docusate sodium` (Colace)	Surfactant — water + fat penetrate stool	Mild cramping; minimal systemic effect	Prevention only — does NOT treat existing constipation. Common post-op / opioid users.
Stimulant	`Bisacodyl` (Dulcolax) `Senna` (Senokot)	Directly stimulates intestinal nerves → ↑ peristalsis	Cramping, dependence, electrolyte loss, melanosis coli	Short-term use only. Don't crush enteric-coated tabs. Don't take with milk/antacids.
Saline / Enema	`Sodium phosphate` (Fleet) Tap water · Soap suds enema	Rapid evacuation of distal colon	Fluid + electrolyte shift, dehydration, rectal trauma	Last-line. Avoid Fleet enema in renal failure & older adults (phosphate nephropathy).
Antimotility	`Loperamide` (Imodium) `Diphenoxylate/atropine` (Lomotil)	μ-opioid agonist in gut → slows peristalsis → ↑ water absorption	Constipation, drowsiness, toxic megacolon	**CONTRAINDICATED in C. diff, bloody diarrhea, fever** — traps toxin. Not for children < 2.

CLASS	DRUGS (EXAMPLES)	MECHANISM	KEY SIDE EFFECTS	NURSING PRIORITY
Adsorbent	Bismuth subsalicylate (Pepto-Bismol)	Coats GI lining, binds toxins, mild antimicrobial	Black stool & tongue (harmless), tinnitus (salicylate)	Contains salicylate — avoid in children/teens (Reye's syndrome) and aspirin allergy.
Probiotic	Lactobacillus Saccharomyces boulardii	Restores normal gut flora	Mild gas, bloating	Useful with antibiotic-associated diarrhea. Avoid in severely immunocompromised.

06 NCLEX TEST TRAPS · WRONG VS RIGHT

Where students lose points

These distractors look helpful — but they hide a priority error. Train your eye to spot the pattern.

✗ WRONG CHOICE	✓ RIGHT CHOICE
"Give Imodium for the watery diarrhea and bring the temperature down with acetaminophen."	**Send a stool culture, hold antidiarrheal, start IV fluids, initiate contact precautions.**

> *Antidiarrheals are **contraindicated** in infectious or bloody diarrhea or fever — they trap toxin and increase risk of toxic megacolon.*

✗ WRONG CHOICE	✓ RIGHT CHOICE
"Use alcohol-based hand sanitizer between patient contacts with the C. diff client."	**Wash hands with soap and water — alcohol gel does not kill C. diff spores.**

> *C. diff is a spore-former. Friction + soap + water are required. This is a frequent NGN priority-action item.*

✗ WRONG CHOICE	✓ RIGHT CHOICE
"Constipated client with hypoactive bowel sounds and vomiting — give a bisacodyl suppository now."	**Hold all laxatives, notify provider, assess for bowel obstruction (NPO, NG tube possible).**

> *Stimulant laxatives in obstruction = perforation. Vomiting + distention + absent bowel sounds is obstruction until proven otherwise.*

✗ WRONG CHOICE	✓ RIGHT CHOICE
"Teach the patient to take docusate sodium (Colace) when constipation occurs."	**Docusate is for prevention, taken daily — it softens, it does not stimulate. Use a stimulant or osmotic for treatment.**

> *Mechanism trap. Stool softeners ≠ laxatives. NCLEX often pairs this with post-op opioid teaching.*

✗ WRONG CHOICE	✓ RIGHT CHOICE
"Diarrhea with K^+ of 2.9 — give 40 mEq potassium IV push to correct quickly."	

Replace K^+ orally if tolerated or IV piggyback diluted — NEVER IV push (fatal arrhythmia). Max 10 mEq/hr peripheral.

> *Potassium IV push = cardiac arrest. This is one of the most-tested safety rules on the NCLEX.*

✗ WRONG CHOICE	✓ RIGHT CHOICE

"Cardiac patient straining at stool — encourage them to bear down to finish."

Avoid Valsalva — provide stool softener, increase fluids, dim lights, allow privacy and time.

> *Valsalva → vagal stimulation → bradycardia, ↑ intracranial pressure, dysrhythmia. Avoid in MI, post-CABG, neuro patients.*

07 PATIENT & FAMILY EDUCATION

What you teach before discharge

Both conditions are heavily lifestyle-driven. Teaching is the long-game intervention.

Constipation Teaching

- ✓ Drink 2–3 L of water daily unless restricted
- ✓ Increase fiber gradually (sudden ↑ = gas, bloating, cramps)
- ✓ Walk daily — 30 min if able
- ✓ Don't ignore the urge — establish a routine (after breakfast is ideal)
- ✓ Use a footstool — squatting position straightens the rectoanal angle
- ✓ Avoid chronic stimulant laxative use → laxative dependence
- ✓ Take fiber supplement with a full glass of water — never dry
- ✓ Report blood in stool, ribbon-like stool, unintentional weight loss, or no BM > 3 days with abdominal pain
- ✓ If on opioids, take stool softener prophylactically every day

Diarrhea Teaching

- ✓ Drink oral rehydration solution (Pedialyte) or broth — not plain water alone
- ✓ Avoid milk and dairy temporarily (transient lactase deficiency)
- ✓ Avoid caffeine, alcohol, fatty foods, very sweet drinks/juice
- ✓ Wash hands with **soap and water** after every toilet use
- ✓ Clean perianal skin gently; apply barrier cream after each stool
- ✓ Don't share towels, utensils, or bathrooms during acute infection
- ✓ Finish prescribed antibiotics even if diarrhea persists — but report worsening
- ✓ Report: blood, fever > 101.4°F, dizziness, no urine for 8 hr, severe abdominal pain, > 6 stools/day
- ✓ If on tube feeding — report; rate or formula may need to be adjusted

08 DIET · FOOD LISTS

Eat this · Avoid this

Diet is the front-line intervention you can teach in 90 seconds. Fiber and fluids for one, bland and binding for the other.

Constipation Diet

HIGH-FIBER · HIGH-FLUID · BOWEL-STIMULATING

FRUITS (HIGH FIBER + SORBITOL)

Prunes | Pears | Apples (with skin) | Berries | Kiwi | Figs | Oranges | Plums | Dates

VEGETABLES

Broccoli | Brussels sprouts | Carrots | Spinach | Kale | Sweet potato | Peas | Artichoke

GRAINS · LEGUMES · SEEDS

Oatmeal | Whole-wheat bread | Bran cereal | Brown rice | Quinoa | Lentils | Black beans | Chickpeas | Flaxseed | Chia seeds

FLUIDS

Water (2–3 L/day) | Prune juice | Warm beverages (AM) | Herbal tea

AVOID / LIMIT

Cheese | Red meat (excess) | White bread | White rice | Processed snacks | Bananas (unripe) | Fast food | Excessive alcohol

Diarrhea Diet

BLAND · BINDING · LOW-FIBER · REPLENISHING

BRAT / BRATY DIET

Bananas (ripe) · **R**ice (white) · **A**pplesauce · **T**oast (white) · **Y**ogurt (plain, w/ probiotics)

Short-term only (≤ 48 hr) — advance to a balanced diet as soon as tolerated.

BLAND · BINDING FOODS

Bananas (ripe) | White rice | Applesauce | White toast | Plain crackers

Boiled potato (no skin) | Pasta (plain) | Oatmeal (small portions)

LEAN PROTEIN (WHEN TOLERATED)

Baked chicken | Baked turkey | Eggs (cooked plain) | White fish | Tofu

FLUIDS & ELECTROLYTES

Oral rehydration solution | Pedialyte | Clear broth | Coconut water | Diluted sports drink

Weak tea (no caffeine) | Plain water

PROBIOTICS

Plain yogurt (live cultures) | Kefir

AVOID DURING ACTIVE DIARRHEA

Milk & dairy (except yogurt) | Caffeine (coffee, soda) | Alcohol | Fatty / fried foods

Spicy foods | Raw fruits/veggies | High-fiber foods | Sugar-free gum (sorbitol)

Apple/pear/prune juice | Beans/legumes | Greasy meats | Artificial sweeteners

09 MEMORY BOOSTERS · MNEMONICS

How to lock it in

Recall patterns under exam pressure beat raw memorization.

F·F·F·F

FOUR F's of Constipation Care

Fiber — 25–35 g/day
Fluids — 2–3 L/day
Fitness — daily ambulation
Foot stool — squat position

BRAT

Diarrhea Diet

Bananas (ripe)
Rice (white)
Applesauce
Toast (white)
(Add Y for plain Yogurt)

DRIP

Diarrhea Causes

Diet (lactose, sorbitol, tube feed)
Rx — antibiotics, laxatives, Mg
Infection (C. diff, viral)
Pathology — IBD, IBS-D

SLOW

Constipation Risk Factors

Sedentary lifestyle
Low fluid / low fiber
Opioids & anticholinergics
Withholding the urge

SOAP

C. diff Handwashing

Soap & water — required
Only soap kills spores by friction
Alcohol gel does NOT work
Precautions: contact + private room

BOSS

Laxative Order of Use

Bulk-forming (1st line, safest)
Osmotic (MiraLAX, lactulose)
Stimulant (bisacodyl, senna)
Suppository / Enema (last resort)

10 NCJMM · 6-STEP CLINICAL JUDGMENT SCENARIO

NGN-style clinical reasoning

Apply the NCSBN Clinical Judgment Measurement Model to a real bedside situation.

THE SCENARIO

A 78-year-old female on a med-surg unit, day 5 post-hip-replacement, on hydromorphone PCA. The nurse notes she has had no bowel movement since admission. She now reports nausea, abdominal cramping, and a feeling of fullness. Vital signs: T 99.2°F, HR 96, BP 138/82, RR 18. Bowel sounds are hypoactive in all quadrants. Abdomen is firm and distended. The PCA log shows steady opioid use. Last documented BM: 5 days ago.

STEP 1

Recognize Cues

5 days without BM · opioid PCA use · hypoactive bowel sounds · firm distended abdomen · nausea + cramping · age 78 · post-op immobility

STEP 2

Analyze Cues

Cue pattern points to opioid-induced constipation with possible early impaction. Rule out obstruction — hypoactive (not absent) sounds + no vomiting suggests constipation, not full obstruction yet.

STEP 3

Prioritize Hypotheses

#1 Opioid-induced constipation with risk for fecal impaction
#2 Early bowel obstruction (rule out)
#3 Dehydration / immobility contribution

STEP 4

Generate Solutions

Hold any stimulant laxative until obstruction ruled out · notify provider · KUB or abdominal exam · increase fluids · ambulate · digital rectal exam if ordered · add bowel regimen (softener + osmotic)

STEP 5

Take Action

Notify provider; obtain order for abdominal imaging; insert IV fluids if not in place; administer docusate + polyethylene glycol per order; ambulate patient; reposition; document I&O

STEP 6

Evaluate Outcomes

Goal: soft BM within 24 hr · bowel sounds return to normoactive · abdomen soft + nontender · pain controlled with reduced opioid need · patient verbalizes bowel regimen plan at discharge

Visual Study Library · 2026 NGN Test Plan

GI · ELIMINATION · V1.0