



Royal College
of Nursing

Management of lower bowel dysfunction, including DRE and DRF

RCN guidance for nurses





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Foreword

Bowel care is a fundamental area of patient care that is frequently overlooked, yet it is of paramount importance for the quality of life of our patients, many of whom are hesitant to admit to bowel problems or to discuss such issues.

In 2008 the National Occupational Standards (NOS) relating to lower bowel dysfunction were developed through a partnership between the Royal College of Nursing (RCN) and Skills for Health, and generously funded by Coloplast Limited. Through the publication of these NOS, the RCN hoped to encourage their widespread adoption across all NHS and independent health care sectors and enable a full understanding of the standards and helping to facilitate best practice.

The popularity of previous RCN publications relating to digital rectal examination and the manual removal of faeces had already demonstrated the strength of interest in the issue of good bowel management and the urgent need for this type of information in the nursing arena.

When the NOS for lower bowel dysfunction were first developed in 2008 it was decided to update this publication, and in March 2008 the RCN published its *Bowel care, including digital rectal examination and manual removal of faeces: RCN guidance for nurses* to coincide with the publication of the Skills for Health NOS relating to continence. This document proved just as popular as previous RCN publications on this topic.

Now in 2012 this excellent resource has once again been updated to incorporate the most recent best practice in bowel care. The revised publication will help nurses to understand the functions of the bowel, the need for appropriate assessment, and provides guidance on how nurses can positively help patients with their bowel disorders.

I would like to thank Fiona Hibberts, Christine Norton and Maureen Coggrave for helping to revise this popular RCN publication.

Wendy Ness RN, MSc,
Colorectal Nurse Specialist, Croydon University Hospital

On behalf of the RCN Continence Care Forum, I would like to express our gratitude to the lead authors, Wendy Ness and Fiona Hibberts, for their willingness and keenness in undertaking the updating of this document. We are also very grateful to Christine Norton and Maureen Coggrave for sharing their clinical expertise.

This is a document that has always been used by practitioners in their day-to-day care of patients, and by others looking for guidance in the formulation of policies and teaching plans. We look forward to having this valuable resource at our fingertips once again.

We are also very grateful to Skills for Health and to Coloplast Limited for their continuing support.

Stephen Miles

Chair RCN Continence Care Forum

I am delighted to be able to support the relaunch of this guidance which has been updated to ensure that nurses have access to the information they need to support best practice. I would like to express my appreciation to everyone who has given a significant amount of time and expertise to this work and in particular to Stephen Miles who has co-ordinated the work.

Amanda Cheesley

RCN Long Term Conditions Adviser

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Introduction

Background

In 2006, the Royal College of Nursing (RCN) and Skills for Health (SfH) jointly identified a need for competences related to continence care. On completion of scoping, development, field testing and approval processes, a competence suite – containing 13 competences for continence care – was produced. These competences, also known as National Occupational Standards (NOS), are statements of competence describing good practice and are written to measure performance outcomes, describing what needs to happen in the workplace.

The NOS are a source of information to help people make informed decisions about:

- the demands of employment
- good practice in employment
- the coverage and focus of services
- the structure and content of education, training and related qualifications.

The competences are designed to be used by all health care professionals and a full insight into NOS can be found at the SfH website at www.skillsforhealth.org.uk

Document aims

This document aims to provide a review of lower bowel dysfunction in adults, digital rectal examination, and guidance on the digital removal of faeces. It expands on the SfH continence care competences relating to lower bowel dysfunction – of which there are five – putting them into a more usable format and creating a benchmark for lower bowel dysfunction that provides RCN endorsement and approval:

- CC01 – assess bladder and bowel dysfunction
- CC08 – care for individuals using containment products
- CC09 – enable individuals to effectively evacuate their bowels
- CC12 – enable individuals to undertake pelvic floor muscle exercises

CC13 – enable individuals with complex pelvic floor dysfunction to undertake pelvic floor muscle rehabilitation.

Produced, consulted on and endorsed by a team of expert practitioners from the four UK countries using the SfH NOS development methodology, this publication brings together and links directives from the RCN, SfH, Essence of Care (EOC) and the National Institute for Health and Clinical Excellence (NICE).

Using this publication

Although this document is written primarily for a nursing audience, it can also be used by other health care professionals to support them in undertaking a wide range of activities relating to many aspects of lower bowel dysfunction. Many of the statements contained in this document reflect essential nursing care and are not of an advanced or complex nature. It is not intended to be a comprehensive document on lower bowel dysfunction or a literature review.

At the start of each section there is a statement (in bold) taken from the SfH continence care competences which relate to lower bowel dysfunction. The section then expands on these, making them easier to use and understand while informing the reader of the key drivers that underpin the critical thinking supporting this document.

This document provides a resource and framework for practice that can be used in a variety of ways, including:

- a practical guide to making the NOS more understandable at a clinical level within nursing
- setting a bowel care standard for best practice in all care settings for nurses
- forming a benchmark to be used to reflect and compare competence and practice within nursing
- a point of reference to support academic work related to bowel care for nurses
- a nursing resource to support the development of guidelines, policies and protocols related to lower bowel dysfunction at local level
- as a guide for the development of lower bowel dysfunction-related clinical procedures
- to support bowel care related nursing assessment
- as a framework on which to develop lower bowel

dysfunction-related teaching material, programmes of learning and courses

- to stimulate nursing audit and research activity in lower bowel dysfunction.

Mapping SfH competences

At the end of most sections examples of SfH competences from other completed SfH competency suites are provided that relate to the aspect of practice and which can be referred to if the reader wishes to expand their knowledge in this aspect of care. These examples were accurate at the time this document went to press.

Who should use this guidance?

This document has been produced to support nurses in a wide range of activities related to lower bowel dysfunction. Those who may find it of value include:

- nurses delivering lower bowel care as part of their role – from the assessment of bowel dysfunction to the delivery of specific lower bowel care interventions
- nurses developing lower bowel dysfunction risk assessment tools
- nurses working within any care setting where lower bowel care is provided
- nurses producing guidelines, protocols, policies and procedures related to lower bowel dysfunction before administration of medicine
- nurses in management posts who supervise, recruit, develop and appraise staff working within lower bowel dysfunction
- nurses developing programmes of learning, teaching and courses which encompass lower bowel dysfunction
- nurses developing, using, and measuring quality bowel care nursing indicators
- nurses undertaking bowel care audit and/or research
- other health care professionals involved in the management of lower bowel dysfunction.

2

Anatomy and physiology

Knowledge and understanding

You will need to know and understand:

- the anatomy and physiology of the male and female lower gastro intestinal tract in relation to lower bowel function and continence status.

The normal colon has five main functions (Winney, 1998).

Storage: the colon stores unabsorbed food residue. Within 72 hours, 70 per cent of this has been excreted. The remaining 30 per cent can stay in the colon for up to a week.

Absorption: sodium, water, chloride, some vitamins and drugs, including steroids and aspirin, are absorbed from the colon.

Secretion: mucus is secreted and used to lubricate the faeces.

Synthesis: a small amount of vitamin K is produced.

Elimination: peristaltic movement of faecal matter into the rectum, where its presence is detected by sensory nerve endings and a sensation of fullness is experienced, followed by a desire to defecate.

Stool production and what influences this (Emmanuel, 2004)

Normal stool output per day is around 150-200g. The proximal colon defines the consistency and volume of delivery of contents to the rectum. Bowel frequency in a healthy person may vary between three times a day to three times a week. Stool consistency can vary (refer to the Bristol Stool Form scale, Heaton et al., 1992) and its production is influenced by gender, diet and health.

Normal defecation (Emmanuel, 2004)

The process of rectal emptying is usually initiated voluntarily. Movement of faeces into the rectum causing rectal distension evokes the desire to defecate, known as the 'call-to-stool'. Under the appropriate circumstances, the person adopts a sitting or squatting position. This

allows straightening of the ano-rectal angle and relaxation of the external anal sphincter and puborectalis muscle. Abdominal pressure is raised and the muscles of the anterior abdominal wall tense to funnel the pressure down to the pelvis. The stool then enters the lower rectum, which initiates a spontaneous recto-sigmoid contraction that pushes the stool through the relaxed anal canal. This is repeated until the rectum is empty; once the last bolus of stool is passed the closing reflex of the external sphincter is stimulated which allows continence to be maintained after the act of defecation.

The nervous system (Emmanuel, 2004)

The rectum and internal anal sphincter receive an extrinsic autonomic innervation from lumbar (sympathetic) and sacral (parasympathetic) nerve roots. This innervation conveys information in each direction between the hindgut (lower bowel) and the brain. Additionally, there is a dense network of local enteric neurones (ENS) in the gut wall which mediate the fine processing of the information from brain to rectum and anus. The ENS is also responsible for the intrinsic organisation of peristalsis and coordinating the whole process. The motor nerve supply to the striated (voluntary) muscle of the external anal sphincter is from the second to fourth sacral spinal cord segments, via the pudendal nerve. The neurological control of the bowel is the result of an intricate balance between the extrinsic and enteric nervous system, and the intestinal smooth muscle cells. Reflex pathways from the central nervous system to the intestine and colon both facilitate and inhibit gut motility.

The pelvic floor muscles (Emmanuel, 2004)

Comprising two layers of muscle; a superficial layer and a deep layer referred to as levator ani (literal translation meaning 'lift the anus'). The levator ani has fascial attachments, via the archus tendineus, levator ani and the archus tendineus fasciae pelvis. The puborectalis muscle component of the pelvic floor contributes to maintenance of the ano-rectal angle that is important

for maintaining continence; appropriate relaxation is essential to the process of defecation.

Anal sphincters

(Emmanuel, 2004)

The internal anal sphincter (IAS) is a smooth muscle that is able to maintain tonic contraction for long periods of time. This sphincter contributes about 85 per cent of the resting anal sphincter tone, which in health is between 60 and 110 cm H₂O. Weakness of the IAS may result in passive faecal incontinence. The external anal sphincter (EAS) is a striated muscle under voluntary control, which contributes only 15 per cent towards resting anal tone. The EAS is responsible for the voluntary contraction of the sphincter; squeeze pressure in health is between 60 and 250 cm H₂O. Weakness or disruption by trauma of the EAS may result in urge faecal incontinence.

Reflex actions

(Emmanuel, 2004)

The gastro colic reflex is initiated when food and/or drink is ingested and sets off movement of the upper and lower gastrointestinal tract. It can be used when teaching patients bowel emptying techniques by suggesting that half an hour after a meal they sit on the toilet to encourage a natural pattern of defecation.

The anal reflex occurs when touching the skin by the anus; it contracts then relaxes. When doing a digital rectal examination (DRE), use this reflex to allow easier insertion of your finger.

The closing reflex occurs at the end of rectal evacuation; the anal sphincter snaps shut to help maintain continence. Patients can enhance this by squeezing their anal sphincter at the end of defecation.

The recto-anal inhibitory reflex results when there is a distension of the rectum, where IAS relaxes and EAS contracts.

3

Definitions and causes of bowel dysfunction

Knowledge and understanding

You will need to know and understand:

- the causes of poor bowel emptying, types of constipation, and how to classify stools by use of an appropriate chart.

Constipation and poor bowel emptying

Bowel habits and perception of bowel habits vary widely, making constipation difficult to define. People with constipation can be divided into two main categories: those with difficulty defecating (but normal bowel motion frequency) and those with a transit abnormality (which can present as infrequent defecation) (Frizelle and Barclay, 2007). Individuals experiencing constipation generally experience an impaired quality of life, compared with the general population (Norton, 2006).

Primary or idiopathic constipation is not apparently associated with any other complaint and has no pathological cause. However, immobility, poor diet, slow colonic transit, and pelvic-floor abnormalities can be linked.

Secondary constipation is secondary to another disorder; whether this is a metabolic, psychological, or neurological disorder, there is a cause for the constipation that can be identified.

Functional constipation is a functional bowel disorder that presents as a persistently difficult, infrequent, or seemingly incomplete defecation. This includes two or more of the following symptoms for at least 25 per cent of defecations; symptoms need to have been in evidence for between three to six months:

- straining during defecation
- lumpy or hard stools
- sensation of incomplete evacuation

- sensation of anorectal obstruction/blockage
- manual manoeuvres to facilitate defecation (for example, digital evacuation, support of the pelvic floor)
- fewer than three defecations per week
- loose stools are rarely present without the use of laxatives (Longstreth et al., 2006).

Obstructive defecation syndrome or rectal outlet delay is demonstrated by a feeling of anal blockage on more than one in four occasions and prolonged defecation (more than 10 minutes to complete evacuation), or the need for self-digitation on any occasion (Harari, 2004), and in individuals with neurogenic bowel dysfunction.

Anismus is an inappropriate contraction (paradoxical sphincter contraction) rather than relaxation of the anal sphincter or puborectalis muscle during defecation. This is sometimes a hidden cause of chronic constipation and needs to be considered when assessing patients.

Faecal impaction or loading is when the rectum, and often the lower colon, is full with hard or soft stool and the patient is unable to evacuate the bowel unaided. This can result in impaction with overflow spurious diarrhoea, which is common in the frail elderly population (Harari, 2004) and in individuals with neurogenic bowel dysfunction. It may be misdiagnosed as diarrhoea and therefore treated incorrectly.

Faecal incontinence

Most people acquire bowel control at a very young age and take the process very much for granted. When something goes wrong, it can be very embarrassing and people are reluctant to seek help. Much is known about the many causes and best management of bowel dysfunction. However, difficulties frequently arise in linking specific symptoms and causes due to the subjective nature of self-reporting.

It is important to diagnose the specific problem and the cause or causes for the individual before treating (NICE, 2007).

Definitions include the following:

- faecal incontinence is defined as the uncontrolled passage of solid or liquid faeces at socially inappropriate times and place (Kenefick, 2004)
- anal incontinence is the involuntary loss of flatus, liquid or solid stool that is a social or a hygienic problem (Norton, 2009)
- passive soiling (liquid or solid) occurs when an individual is unaware of liquid or solid stool leaking from the anus; this may be after a bowel movement, or at any time.

Causes include the following:

- passive soiling – poor internal anal sphincter pressure is the most likely cause, and may be a result of inadvertent surgical damage, for example, following haemorrhoidectomy
- urgency and urge faecal incontinence is when the individual has to rush to the toilet, or is unable to get there in time resulting in a bowel accident; external anal sphincter weakness or defect is a common cause, often due to obstetric trauma (Sultan, 1994)
- increased gut motility causing loose stools – infection, inflammatory bowel disease, irritable bowel syndrome diet or stress ano-rectal pathology – rectal prolapse, fistula, haemorrhoids
- neurological disease – spinal cord injury, cauda equina syndrome, multiple sclerosis, spina bifida, dementia
- lifestyle and environmental issues – poor toilet facilities, diet, dependence on carers for mobility and managing clothing
- idiopathic or unknown cause.

Chronic diarrhoea is defined as the frequent (more than three times daily) passage of unformed stool for one month or more (Talley and Martin, 1996). Persistent diarrhoea may be a feature of a chronic disease such as inflammatory bowel disease, irritable bowel syndrome and coeliac disease.

Diarrhoea

Diarrhoea is loose, watery stools. Acute diarrhoea is a common problem that presents as a sudden onset, lasts less than two weeks and usually resolves on its own without special treatment (digestive.niddk.nih.gov, 2007).

4

Assessment, investigations (including DRE), diagnosis and prognosis

Assessment

Knowledge and understanding

You will need to know and understand:

- **how to adapt continence assessment to the health status of the individual for example, in end-of-life care, chronic long term conditions, post childbirth, infective diarrhoea, disability.**

Use a structured approach in the assessment of patients with bowel dysfunction according to evidence based guidance (NICE, 2007). Ensure that appropriate practitioners are capable of undertaking the assessment as required, and that the assessment is initiated with sensitivity so as to minimise a patient's embarrassment.

Ensure that the environment and equipment are clean and suitable for the assessment, and adapt your communication to reflect individual patient requirements (Norton and Chelvanayagam, 2004). Explain the process of assessment and gain valid informed consent.

The assessor needs to be aware of the different types of assessment including planned, routine, unscheduled, first assessment, self-assessment or review.

It is important to recognise the importance of including risk assessment within the wider assessment process in order to identify high risk individuals or factors such as bowel cancer, severe faecal impaction, *Clostridium difficile* (NICE, 2007). The assessor needs to be able to select, administer and interpret self-assessment questionnaires and scales as part of the bowel assessment.

Signs and symptoms may include a patient's own account of the condition, frequency of passage of stools, consistency of stools (according to the Bristol Stool Form scale), any rectal bleeding, unintentional weight loss, anaemia, pain before, during or after defecation, faecal leakage, and faecal urgency (Norton and Chelvanayagam, 2004).

During the assessment identify any specific

requirements the individual may have. These may include personal details, surgical, medical, obstetric, family, neurological history, any assessments already undertaken, home and social circumstances and functional capabilities, allergies, diet, fluids and smoking status (Norton and Chelvanayagam, 2004). The need for assistance with bowel care and available resources should be explored.

Assess the impact of the bowel dysfunction on the patient's quality of life (Chelvanayagam and Wilson, 2004). Evaluate how certain categories of medication affect bowel function, including prescribed medication, over the counter, internet obtained and recreational use.

Accurate details of an individual's dietary habits should be elicited, as diet affects bowel function. This should be monitored by completing a food diary (Norton and Chelvanayagam, 2004; Norton and Kamm, 2001). The assessor should have knowledge of when to refer for specialist dietetic assessment.

Bowel diaries can help to identify problems, frequency of bowel evacuation, stool consistency, where bowel evacuation occurs and faecal incontinence (Norton and Chelvanayagam, 2004).

Fluid intake affects bowel function. The amount of fluid consumed and type should be considered (Norton and Chelvanayagam, 2004; Norton and Kamm, 2001).

Carry out baseline observations to support the bowel assessment and aid a differential diagnosis. These observations should include body mass index (BMI), stool observation (including frequency, consistency, Bristol Stool Form scale, amount, any faecal leakage or soiling, rectal bleeding, pain) and functional ability to use the toilet (Norton and Chelvanayagam, 2004).

Discuss with the individual the findings of the assessment, including likely causes, implications, risks, conclusion and differential diagnosis. Also review the need for further investigations and treatment choices/recommendations.

Mapping SfH competences to this aspect of practice:

- assess bladder and bowel dysfunction CC01
- plan assessment of an individual's health status CHS38
- plan inter-disciplinary assessment of the health and wellbeing of individuals CHS52
- assess an individual's health status CHS39
- provide advice and information to individuals on how to manage their own condition GEN14
- determine a treatment plan for an individual CHS41
- agree a plan to enable individuals to manage their health condition PE4
- monitor and assess individuals following treatments CHS47.

Investigations

Knowledge and understanding

You will need to know and understand:

- **the further investigations and interventions that may be required for bowel dysfunction.**

Nurses need to understand why the following investigations are performed, what they involve, what information can be gained from them, and how they can aid diagnosis:

- digital rectal examination (DRE)
- bowel and food diary (Norton and Chelvanayagam, 2004)
- visualisation, such as proctoscopy, sigmoidoscopy, colonoscopy (Nicholls, 2004)
- anorectal physiology testing which may include anal manometry, rectal sensation using balloon distension (Nicholls, 2004)
- radiographic investigations and scans, for example endo anal ultrasound, proctogram, barium enema or meal, plain abdominal, transit studies, magnetic resonance imaging scan and computerised tomography scan
- stool observation, including consistency, frequency, Bristol Stool Form scale and amount (Norton and Chelvanayagam, 2004)
- stool specimen.

Digital rectal examination (DRE)

Core skills, knowledge and qualifications

A digital rectal examination (DRE) can be undertaken by a qualified/registered nurse who can demonstrate professional competence to the level determined by the Nursing and Midwifery Council (NMC) in its *Code of professional conduct* (NMC, 2008). This requires registered nurses to practise competently, possessing the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision; to acknowledge the limits of their professional competence; and only to undertake practice and accept responsibilities for those activities in which they are competent.

A qualified nurse who can demonstrate competence to this professional level may be expected to delegate care delivery to others who are not registered nurses or midwives such as health care workers/carers. Such delegation must not compromise existing care, but must be directed to meeting the needs and serving the interests of patients and clients. The qualified nurse remains accountable for the appropriateness of the delegation, for ensuring that the person who does the work is able to do it, and that adequate supervision or support is provided.

When to perform DRE

DRE may be used as part of a nursing assessment in conjunction with the assessment process. When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can be easily viewed.

DRE can be used in the following circumstances to:

- establish the presence of faecal matter in the rectum; the amount and consistency
- ascertain anal tone and the ability to initiate a voluntary contraction and to what degree
- establish anal and rectal sensation
- teach pelvic floor exercises
- assess anal pathology for the presence of foreign objects
- prior to giving any rectal medication to establish the state of the rectum
- to establish the effects of rectal medication

- assess the need for and effects of rectal medication in certain circumstances
- administer suppositories or enema prior to endoscopy
- determine the need for digital removal of faeces (DRF) or digital rectal stimulation and evaluating bowel emptiness
- evaluate bowel emptiness in neurogenic bowel management; in other words, after use of suppositories, enemas or transanal irrigation.

Before carrying out a DRE the perineal area should be observed for any abnormalities which need to be documented and reported as necessary:

- rectal prolapse – grade, ulceration
- haemorrhoids – grade, internal or external
- anal fissure
- anal skin tags
- wounds – dressings and discharge
- anal lesions – possible malignancy
- anal fistula/induration
- anal tone absent/reduced
- increased skin conditions (such as psoriasis or eczema)
- broken areas or sore/red skin
- pressure sore – grade
- blood – colour
- faecal matter
- scarring – possible previous surgery or damage through childbirth
- infestation
- foreign bodies.

Exclusions and contraindications for undertaking a DRE

Nurses should not undertake a DRE or DRF when:

- there is a lack of consent from the patient – written, verbal or implied
- the patient's doctor has given specific instructions that these procedures are not to take place.

Circumstances when extra care and multi disciplinary discussion is required

Nurses should exercise particular caution when performing a DRE or DRF with patients who have the following:

- active inflammation of the bowel, including Crohn's disease, ulcerative colitis and diverticulitis
- recent radiotherapy to the pelvic area
- rectal or anal pain
- rectal surgery or trauma to the anal or rectal area (in last six weeks)
- tissue fragility due to age, radiation, or malnourishment
- obvious rectal bleeding – consider possible causes for this
- a known history of abuse
- SCI patients with an injury at or above the sixth thoracic vertebra due to the risk of autonomic dysreflexia
- if patient has a known history of allergies such as latex.

When a nurse specialist or practitioner may use DRE

Nurse specialists or practitioners are now involved in additional areas of care that involve undertaking DRE. These nurses might use DRE for a variety of reasons during the following procedures:

- anorectal physiology studies; for example anal manometry and rectal sensation
- endo anal ultrasound scan
- the placement of a rectal probe or sensor before undertaking a urodynamic study
- the placement of a probe used for electrical stimulation of the pelvic floor muscles
- the placement of rectal catheters used in the treatment of obstructive defecation and/or biofeedback
- prior to using trans anal irrigation
- the placement of an endoscope when undertaking a sigmoidoscopy or colonoscopy
- to assess prostate size, consistency, mobility and anatomical limits.

Diagnosis and prognosis

Knowledge and understanding

You will need to know and understand:

- the aspects of individuals' and their families' past medical history which may be relevant to the assessment and diagnosis
- the interpretation of results from further investigations, and how these inform a diagnosis for individuals with bladder and/or bowel dysfunction.

When making a diagnosis of a suspected health condition it is necessary to have a critical understanding of how to interpret evidence from an individual's history, baseline observations and tests and further investigations. There is a difference between assessment and diagnosis, and one is necessary for the other (SfH, CHS40). As nurses we contribute to diagnosis within the multidisciplinary team.

Faecal incontinence or constipation are often symptoms with multiple contributing factors. It is important to avoid making simplistic assumptions that the cause is related to a single primary diagnosis – known as 'diagnostic overshadowing' (NICE, 2007). For example, a patient with multiple sclerosis (MS) may have faecal incontinence as a consequence of a sphincter defect following childbirth, and not as a direct of consequence of MS.

Once a diagnosis has been established, the prognosis of the problem needs to be discussed with the patient so they are aware of how this will affect their life. It may be that the problem will not improve and they need to employ coping strategies to manage. If the problem is not curable, certain treatments – behavioural, diet or medication – may improve the problem to a more manageable level.

Mapping SfH competences to this aspect of practice:

- enable individuals to make informed health choices and decisions PE1
- establish a diagnosis of an individual's health condition CHS40
- prepare individuals for health care activities GEN4
- determine a treatment plan for an individual CHS41
- agree a plan to enable individuals to manage their health condition PE4.

5

Interventions to improve and maintain bowel function (including DRF and rectal irrigation)

Knowledge and understanding

You will need to know and understand:

- **how lifestyle, diet and fluids affect bowel function.**

Nurses need to be aware of simple interventions which can improve or maintain bowel function, and what the desired outcome would be for each individual patient.

These include:

- healthy lifestyle advice – including weight management and smoking cessation, fluid advice, diet adjustment, exercise
- individualised programme of pelvic muscle exercises, biofeedback (sensory, auditory or visual) and electrical stimulation as appropriate
- regular routine for bowel emptying – reflecting current needs and previous history where relevant, using a personalised programme of interventions
- maximise gastric colic reflex and natural body functions by suggesting that the patient empties their bowels 30 minutes after a meal
- abdominal massage
- rectal medication, including suppositories, enemas
- equipment – including a foot stool to enable the patient to get into the correct position for defecation, commodes, aids to wiping and suppository inserters
- bowel retraining programmes – including toileting
- bowel emptying techniques – including DRF, digital rectal stimulation, transanal irrigation, positioning and correct defecatory dynamics to reduce incorrect straining techniques
- medication management – including anti-diarrhoeal, laxatives or bulking agents
- toilet substitutes and adaptations
- the National Key Scheme (NKS) which offers independent access to disabled people to around 7,000 locked public toilets and is supported by The Royal Association for Disability and Rehabilitation (RADAR)
- urgency cards – these are the size of a credit card and inform others that the person has a medical condition that may cause a need to use a toilet urgently
- facilitate the individual to talk about problem with friends and relatives (NICE, 2007)
- advice on continence products and information about product choice, availability and use (NICE, 2007)
- psychological and emotional support (NICE, 2007)
- advice on skin care (NICE, 2007).

Mapping SfH competences to this aspect of practice:

- care for individuals using containment products CC08
- enable individuals to effectively evacuate their bowels CC09.

Nutrition

Health care professionals should recommend a diet that promotes an ideal stool consistency and predictable bowel emptying, as well as more general health needs. When addressing food and fluid intake, health care professionals should (NICE, 2007):

- take into account existing therapeutic diets
- ensure that overall nutrient intake is balanced
- use a food and fluid diary to help establish a baseline
- advise patients to modify one food at a time, if attempting to identify potential contributory factors to their symptoms

- screen people with faecal incontinence for malnutrition, or risk of malnutrition
- cultural and religious beliefs need to be taken into consideration
- consider the 5 a day initiative (DH, 2003)
- the low FODMAP diet and British Dietetic Association (BDA) irritable bowel syndrome diet sheet (NICE, 2008); for information on FODMAP visit www.kcl.ac.uk/medicine
- onward referral to dietitians/nutrition team when more specialised knowledge is required.

Diet advice

Consider whether any of the following interventions may improve bowel function, as some people might have intolerances to certain foods which could make their problem worse:

- low residue – reducing fibre could decrease motility of the gut, making the stool firmer
- wheat or dairy – possible food intolerance causing a loose stool or bloating
- exclusion diets – to establish trigger foods that may be causing the dysfunction such as highly fermenting foods such as beans/pulses
- bulkers, such as whole grain cereal or porridge – may bulk the stool, to soften hard stool or firm loose stool
- increase fibre intake (by increasing intake of fruit and vegetables and fibre foods such as wholemeal bread, wholegrain cereals) – the Department of Health (DH) (2003) recommends that adults should eat an average of 18g of fibre a day
- eat small regular meals rather than one large one
- spicy foods – may irritate the bowel increasing motility
- supplementary feeds – may induce diarrhoea
- probiotics and prebiotics – may improve the balance of bacteria within the bowel
- fibre supplements for loose stool and FI (Bliss et al., 2001)
- no real evidence for fibre supplements for constipation (Muller-Lissner et al., 2005).

Fluid advice

The British Dietetic Association recommends between 1.5l and 2.5l of fluid daily for the general adult population, depending on level of activity and prevailing weather conditions (BDA, 2006). Urine colour is correlated with the concentration of urine; urine of a pale straw colour indicates adequate hydration (BDA, 2006), and is a simple rule of thumb which is useful to patients (Coggrave 2008).

Fluid advice and guidance should incorporate a review of the following:

- milk – possible intolerance
- coffee/ caffeine – may increase motility of bowel
- diet drinks – may contain sorbitol which could act as a laxative
- herbal teas – peppermint, fennel and ginger aid digestion
- alcohol – excessive quantity can increase bowel motility.

Mapping SfH competences to this aspect of practice:

- review and monitor a patient's nutritional wellbeing CHS92
- agree a dietary plan for an individual with a specified medical condition CHS93
- provide food and drink to promote individuals' health and wellbeing SCDHSC0213
- support individuals to eat and drink SCDHSC0214
- monitor and review individuals' progress in relation to maintaining optimal nutritional status CHS149.

Skin care

Knowledge and understanding

You will need to know and understand:

- **how to advise individuals with regard to skin cleansing and preparation, prior to the fitting of containment products.**

Knowledge of anatomy and physiology of healthy skin, the damage caused by pressure, and predisposing risk factors is necessary when assessing the individual with bowel dysfunction (SfH CHS4, 2004).

Factors which might exacerbate risk of skin breakdown are poor health, general frailty, immobility, aging, loss of sensation and/or muscle bulk due to neurological conditions, prolonged periods of sitting on hard toilet seat, diabetes mellitus, poor nutritional intake, skin dryness, continuous passive soiling or profuse diarrhoea (NICE, 2007) plus those who wear disposable containment products.

Skin care for individuals with faecal incontinence is a routine task that is integral to essential patient care, as faeces can rapidly affect the integrity of perianal skin. Repeated cleansing with alkaline soap, coarse washcloths and prolonged exposure to enzymes from incontinence decrease the skin's integrity, subsequently putting the individual at risk of developing incontinence associated dermatitis (IAD) (Nix, 2004); Clever et al., (2002) clearly demonstrate that skin cleansing and skin protection decreases IAD. Choosing an agent that cleans, moisturises and protects the patient's perineal skin following an incontinent episode is important.

There is a profusion of literature advocating what to use and what to avoid. The overriding aim is to clean, moisturise and protect the patient's skin thus avoiding skin breakdown. Ripley (2007) asserts that: ...organisations could make substantial cost savings if they replaced soap and water with no-rinse cleansers... NICE (2007) suggest that foam cleansers can be a good alternative to soap and water in preventing skin deterioration. When necessary to dry the skin, it should be patted gently with soft toilet paper or a soft towel (Norton and Kamm, 2001). Avoid using creams or lotions in the perianal area unless specifically advised, as this can make the area sweaty and uncomfortable. Be aware of allergy and hypersensitivity to products. Regular evaluation and inspection of the at risk patient's skin by a competent health care professional is paramount in recognising any complications associated with incontinence. A comprehensive continence assessment and subsequent effective management of bowel dysfunction is the best preventive measure (DH, 2000). In essence, the definitive treatment of IAD would be the successful treatment of incontinence.

Individuals with reduced sensation due to neurological conditions are at high risk of pressure damage associated with toileting. The use of padded toilet seats should be considered and prolonged sitting on toilets/commodors/shower chairs should be avoided. Regular inspection of the skin after toileting is essential.

Toilet tongs or a bottom wiper can extend the reach of an individual who may have limited shoulder or hand strength or flexibility (Norton and Chelvanayagam, 2004). Toilets which include cleansing and drying modalities may be of benefit for individuals with limited arm and hand function.

Mapping SFH competences to this aspect of practice:

- undertake tissue viability risk assessment for individuals CHS4
- care for individuals using containment products CC08.

Containment

Knowledge and understanding

You will need to know and understand:

- **the principles and practice with regard to the management of temporary or intractable bladder and/or bowel dysfunction and how to achieve effective and acceptable social continence status for individuals**
- **how to educate individuals in recognising skin-related complications and the actions to take in relation to the usage of containment products.**

Individuals that have a bowel dysfunction problem may need some kind of containment – anal plugs, pads or a faecal collector – to help them manage their condition with dignity. There are a limited number of products that are both reliable and specifically designed for containment of faecal leakage, and nurses need to be aware of the different products that are available. The smell of faeces is difficult to contain or disguise; consequently using a neutraliser or perfume spray may be helpful.

Anal plugs are useful for patients with passive faecal incontinence (leakage of faeces from the anus without being aware) and are available on the drug tariff. The plug, which is soft slightly absorbent foam, is inserted into the rectum and opens up like a cup shape which reduces faecal leakage. The plug should be tried for a short time initially, as it can irritate the rectum. Used on a continuous basis for up to 12 hours, it may give patients more confidence; for example, when going swimming or to an important social function.

Competent assessment is required before a trial of anal plugs is advised, as it is not appropriate for some individuals.

Pads are available in a range of sizes and the option selected is dependent on the patient's degree of incontinence. Nurses should be aware of both pad suitability and design, and any local agreements relating to pad usage. Nurses should be aware that the use of pads in individuals with neurological conditions that reduce sensation, and who are wheelchair users, may increase the risk of development of pressure ulcers.

Faecal collectors are useful for patients with liquid faeces. Originally designed for use in intensive care situations, they are unlikely to work if the user is seated. The collector is a bag with an opening which is cut to fit around the anus. A flange of flexible foam, backed with a skin barrier, attaches to the skin around the anus for containment of liquid stool.

Bowel management systems are used to contain diarrhoea. A tube-like device is placed into the rectum and the liquid stool drains down an opaque tube into an enclosed bag. These are used primarily for bed bound patients with severe diarrhoea, such as clostridium difficile.

Spare skincare kits can be used when an individual is out and about, and has a bowel accident. The kit could contain wet wipes (not containing alcohol), a small empty plastic bottle which can be filled with water, a spare pad, disposable bag, a peg to hold clothes up, small neutraliser spray and a mirror.

Explain the use and expected outcomes of containment products to individuals, and provide them with the necessary supporting information. This may be in the form of a demonstration of how to fit the chosen product, supported by written information (as it is unlikely that the patient will retain all the information given to them). Review the suitability and use of the selected containment product and clearly document with any agreed follow up action.

Note: the individual needs to dispose of containment products and associated waste safely and effectively.

Mapping SfH competences to this aspect of practice:

- care for individuals using containment products CC08.

Effective bowel evacuation

Knowledge and understanding

You will need to know and understand:

- how to select an appropriate and acceptable bowel emptying technique, or combination, for an individual
- the use of aids, adaptations and foot stools that assist with the use of a toilet, and enhance effective defecation and bowel evacuation
- the correct positioning of the individual related to the particular bowel emptying technique being used.

Nurses need to know different bowel emptying techniques to enable the individual to evacuate their bowel effectively, which in turn could improve their bowel function and improve their quality of life.

Before initiating any bowel emptying technique, explain it to the individual and describe what is involved, expected outcomes, side-effects and any complications.

Be sure that any bowel emptying technique used has an evidence-base and where possible links to international, national, local protocols, procedures and guidelines. The nurse needs to be aware of the particular risks associated with specific bowel emptying techniques, and select an appropriate and acceptable bowel emptying technique or combination for an individual (SfH, CC09, 2008). The following is an overview of bowel emptying techniques.

Positioning – feet elevated on a stool to ensure that knees are above hips, leaning forward in between knees, back straight with lower abdomen bulged.

Dynamics of defecation – with the abdominal wall braced to stop anterior movement, the patient should use the diaphragm to increase intra abdominal pressure from above and, with simultaneous relaxation of the external anal sphincter and puborectalis, should be able to extrude the stool through the anal canal held in the correct position by the levator ani muscles – that is, without perineal descent.

Perineal support – while doing the above manoeuvres supporting, with two fingers, the skin between the anus and vagina.

Vaginal digitation – usually used when an individual has a posterior vaginal wall prolapsed (rectocele). This involves putting the thumb or first finger into the vagina and pushing backwards, and is an accepted way to aid defecation to make lower bowel dysfunction more manageable especially if surgery is not an option.

Digital stimulation of the rectum – done by the individual or nurse/carer by inserting a gloved lubricated finger into the anus and slowly rotating the finger in circular movements, maintaining contact with the rectal mucosa and gently stretch the anal canal (Coggrave, 2008; MASCIP, 2009). This helps to relax the sphincter and stimulates the rectum to contract, and is often used in SCI and other neurological patients. See Appendix 3 on page 41.

Rectal stimulant medication – the main rectal medications are suppositories and enemas. When giving rectal medications, especially enemas (specifically phosphate), the nurse needs to be aware of the contraindications of giving these; be aware that giving anything rectally has associated risks with it. For some individuals, however, rectal medication is a regular part of lower bowel care, used to trigger evacuation as part of a regular bowel management programme.

When to use rectal irrigation – transanal irrigation with warm water is used to facilitate evacuation of stool from the descending colon and rectum. It can be used in a number of clinical scenarios such as chronic constipation, faecal incontinence, obstructive defecation, secondary to for example a rectocele, or neurogenic bowel dysfunction. Transanal irrigation should usually only be tried if other, less invasive, methods of bowel management have failed to adequately control constipation or faecal incontinence.

Since the advent of the first purpose-designed and CE marked rectal irrigation kit (Peristeen Anal Irrigation, Coloplast Limited) on prescription in the UK means that this procedure can now be implemented much more widely in clinical practice (Norton, 2011). However this system does not suit all patients and other equipment used for rectal irrigation could include using gravity or an electric pump where the water may be introduced into the bowel through a cone tip manually held in place in the anus.

It is important to carry out a full individualised assessment of patient suitability prior to commencing any kind of irrigation and obtain informed consent.

Indications for use (Norton, 2011):

- neurogenic bowel dysfunction, – spinal cord injury, spina bifida, MS
- chronic constipation, including both evacuation difficulties and slow transit constipation
- chronic faecal incontinence.

Relative contraindications (use only after careful discussion with relevant medical practitioner):

- pregnant or planning pregnancy
- active perianal sepsis
- diarrhoea
- anal fissure
- large haemorrhoids that bleed easily
- faecal impaction
- past pelvic radiotherapy which has caused bowel symptoms
- known diverticular disease
- use of rectal medications for other diseases
- congestive cardiac failure
- anal surgery within the past six months.

Absolute contraindications (irrigation should not be used):

- acute active inflammatory bowel disease
- known obstructing rectal or colonic mass
- rectal or colonic surgical anastomosis within the last six months
- severe cognitive impairment (unless carer available to supervise/administer).

The trans anal irrigation systems are designed for self administration by patients, even if dexterity is poor. To reduce risks, it is important that the patient is taught how to use the system by a competent health care professional.

Digital removal of faeces (DRF)

Digital removal of faeces (DRF) is an invasive procedure (see Appendix 2 on page) and should only be performed when necessary, and after individual assessment. Cultural and religious beliefs need to be considered before performing this procedure.

In some circumstances, conflict between the patient or carer and nurse over the need for the DRF can create difficulties. In these circumstances, multidisciplinary consultation is advised.

Now that a wider range of bowel emptying techniques are available, the need to use DRF is sometimes questioned; however in certain patients it is a necessary part of their bowel care.

Patients with spinal cord injuries

For some patients, such as those with spinal cord injuries (SCI), DRF is an integral part of their routine. This essential routine should not be interrupted, regardless of the setting in which care is provided. If this procedure is questioned for a particular patient, before making any changes in bowel management and to prevent distress in the individual concerned, it may be helpful to discuss the proposed change with the patient's spinal cord injury centre to ensure that other methods of evacuation are suitable.

The National Patient Safety Agency (NPSA, 2004) has supported the use of DRF in spinal cord injured patients, particularly when admitted to general health care settings. Health care staff must recognise that many individuals with an SCI utilise and are dependent on DRF as part of their established bowel management programme. The failure to support people with a spinal cord injury who need DRF results in ineffective bowel management. This inevitably results in faecal loading and impaction, increasing the risk of autonomic dysreflexia.

When nurses may undertake DRF

DRF may be undertaken in the following circumstances:

- when other methods of bowel emptying fail or are inappropriate
- faecal impaction or loading
- incomplete defecation
- inability to defecate

- neurogenic bowel dysfunction
- in many patients with spinal cord injury.

DRF as an acute or ongoing intervention

When performing a DRF as an acute intervention, or as part of a regular package of care, it is important to carry out an individualised risk assessment. While undertaking DRF the following should be performed or observed for:

- blood pressure in SCI patients who are at risk of AD, prior to and at the end of the procedure, a baseline blood pressure is advised for comparison; for such patients where this is a routine intervention and tolerance is well established, the routine recording of blood pressure is not necessary
- distress, pain, discomfort
- bleeding
- collapse
- stool consistency.

Mapping SfH competences to this aspect of practice:

- enable individuals to effectively evacuate their bowels CC09
- enable individuals to make informed health choices and decisions PE1
- agree a plan to enable individuals to manage their health condition PE4
- develop relationships with individuals which support them in addressing their health needs PE5
- enable individuals to manage their defined health condition PE8.

Surgical interventions

Knowledge and understanding

You will need to know and understand:

- the types of surgical interventions used to improve bowel function: the main types of operations, broad main outcomes of specific surgical procedures and be able to select appropriate individuals for surgery.

Nurses need to understand the types of surgery, why

these are performed, the implications if carried out, and if appropriate be able to identify patients who are appropriate for surgery, and be able to discuss the expected outcomes with the patient.

For faecal incontinence

Secondary sphincter repair, sacral nerve stimulation, artificial bowel sphincter, graciloplasty, stoma.

For constipation/associated problems

Antegrade continent enema (ACE) procedure, continent colonic conduit, sacral nerve stimulation, subtotal colectomy and stoma.

For bowel prolapse/rectocele

Rectopexy, delormes, rectocele repair, posterior repair, stapled transanal rectal resection (STARR).

Mapping SfH competences to this aspect of practice:

- contribute to the development of the multidisciplinary team and its members GEN40
- agree courses of action following assessment to address health and wellbeing needs of individuals CHS45
- monitor and assess individuals following treatments CHS47
- provide advice and information to individuals on how to manage their own condition GEN14.

6

Pelvic floor muscle training, sphincter exercises, biofeedback and electrical stimulation

Knowledge and understanding

You will need to know and understand:

- how to assess the suitability of pelvic floor muscle rehabilitation for individuals
- how to develop an appropriate rehabilitation programme.

People who continue to have episodes of faecal incontinence after initial treatment should be considered for specialist assessment and management. This may involve pelvic floor muscle training, biofeedback and electrical stimulation. Some of these treatments might not be appropriate for people who are unable to understand and or comply with instructions (NICE, 2007).

Pelvic floor muscle training programme is a progressive and intensive programme of voluntary pelvic floor muscle contractions used to attempt to strengthen, improve the endurance of and speed of response of the pelvic floor muscles and requires at least three months of intensive exercise to produce improvement. This improvement is dependent on many factors, including patient motivation and conforming to a programme specific to them. The progress of the individual should be monitored by digital reassessment carried out by a competent health care professional (NICE, 2007).

Biofeedback techniques have been used frequently in the last 20 years for the clinical management of defecation disorders such as anismus (Heymen et al., 2007). Biofeedback helps establish a change in the patient's behaviour, and is a technique that transforms some aspect of physiological behaviour into some kind of visual or auditory signal (Gatchel, 1997). It can be used to aid the teaching of voluntary pelvic floor muscle contraction and relaxation of the pelvic floor.

Neuromuscular electrical muscle stimulation (NMES) may be used in the case of extremely weak muscles or muscles with poor endurance. An electrical stimulus

may be given to the external anal sphincter and pelvic floor muscles via an electrode. The method of choice is usually an intra-anal electrode, although in certain circumstances external skin electrodes may be used. This treatment should only be administered by a competent health care professional following individualised assessment.

Mapping SfH competences to this aspect of practice:

- assess bladder and bowel function CC01
- enable individuals to undertake pelvic floor muscle exercises CC12
- enable individuals with complex pelvic floor dysfunction to undertake pelvic floor muscle rehabilitation CC13
- maintain health, safety and security practices within a health setting GEN16
- communicate effectively in a health care environment GEN97
- obtain valid consent or authorisation CHS167
- assess risks associated with health conditions CHS46
- support individuals undergoing health care activities GEN5
- monitor and assess individuals following treatments CHS47
- evaluate the delivery of care plans to meet the needs of individuals CHS53
- maintain use of medical devices to assist organ or system function CHS166 and maintain health care equipment, medical devices and associated systems CHS210
- decommission medical devices and associated systems within health care CHS211
- plan the maintenance of equipment and medical devices within health care CHS197.

7

Pharmacology and prescribing

Knowledge and understanding

You will need to know and understand:

- how certain categories of medication and how individual's current medication may affect bowel function.

Prescribing medication (RCN, 2006)

Increasingly, nurses are prescribing independently or through group protocols. This allows the supply and administration of prescription-only medicines by nurses, without the need for prior consultation with, or prescription from, a medical practitioner. If you are nurse prescriber and your patient is a child (under the age of 16), note that the nurse prescriber's formulary states that nurse prescribers should discuss with a doctor before prescribing a laxative for a child.

Even if you don't prescribe drugs, the RCN believes that all nurses administering medicines as part of their practice should understand the medication they use, irrespective of whether they have the legal right to prescribe.

The nurse needs to be aware of the ethical, safety, legal and professional implications of recommending complimentary therapies, and unlicensed and untested substances, in the treatment of bowel dysfunction.

Drugs that cause bowel dysfunction (Getliffe and Dolman, 2007)

Many prescribed drugs may have possible side-effects on gut motility and stool consistency, causing loose stool or constipation. The main groups are:

- opioids
- broad-spectrum antibiotics
- laxatives
- diabetic medication
- obesity medication
- antidiarrhoeal
- antidepressants

- antihistamines
- anticholinergics
- antacids
- iron preparations
- polypharmacy.

Changing medications or modifying the regimen may help to improve bowel dysfunction. Polypharmacy refers to the use of multiple medications by a patient. Every medication has potential side effects, and with every drug added there is an increase in possible side effects.

Drugs used to treat bowel dysfunction

Oral and rectal pharmacological interventions are available to treat bowel dysfunction, and can be combined with bowel emptying techniques to enhance the effectiveness of these for the individual. When prescribing, recommending and administering rectal or oral medication, consideration should be given to the indications, hierarchy of choice, usage times, duration of treatment, licensed usage, local formularies, types of bowel dysfunction used for, cautions, contraindications, side effects, interactions and expected outcomes.

Faecal incontinence (NICE, 2007)

Anti diarrhoeal medication – typically used to treat faecal incontinence (FI) and may be a sole treatment option or an adjunct to another therapy. Loperamide is the most commonly used medication in the treatment of FI, and can be given as a regular treatment or on an as-required basis. Introduce at a very low dose and increase until desired stool consistency is reached. Consider Loperamide syrup for doses less than 2mg (NICE, 2007).

Drugs to promote bowel emptying – FI can be secondary to faecal impaction or constipation. Laxatives or rectal evacuators may be used to promote complete rectal emptying.

Constipation

Bulk-forming agents – available in powder, granule or tablet form. These can help retain water in the stool and increase bulk; it is essential to maintain a fluid intake or symptoms of constipation may worsen. They can also be used to give bulk to loose stools.

Stimulants – will induce a bowel movement within 8-12 hours by increasing peristalsis in the colon. Not to be taken if there is a risk of intestinal obstruction.

Osmotic laxatives – retain fluid in the stool and increase bulk by bacterial fermentation. These agents may take up to 48 hours to act, and should be given with plenty of water.

Macrogol – when mixed with water the solution remains in the colon, achieves an increase in faecal bulk that causes stretching of the circular muscle in the bowel wall, triggering peristalsis. Faecal residue is softened and stools are re-hydrated. Some of these preparations are licensed to treat faecal impaction.

5-HT₄ agonists – works by stimulating the 5-HT receptors of the intestine causing an increase in peristalsis.

Faecal softeners – used where it is not possible to successfully promote a soft, formed stool through manipulation of diet and fluids.

Enemas and suppositories – may be used in the acute situation, before or after surgery, or in chronic conditions where the mechanism of normal bowel emptying is disrupted. Phosphate enemas should be used with caution (Davies, 2004).

Mapping SfH competences to this aspect of practice:

- administer medication to individuals CHS3
- provide advice on symptoms and the actions and uses of medicines PHARM04.

8

Lower bowel care emergencies and complications

Lower bowel care emergencies and complications are very rare but it is important that nurses are aware of these and can act quickly to reduce further complications.

Bowel obstruction can be associated with no bowel activity or lots of painful activity to try to bypass a mechanical obstruction, abdominal pain and distension, vomiting, possible dehydration and is a serious condition that requires immediate medical attention. If untreated, the bowel may rupture and leak its contents and cause peritonitis and possible death (Medline Plus, 2007). Main causes are: colon cancer, adhesions, scarring from infection which may narrow the lumen of the colon and volvulus.

Perforation is a hole in the bowel, which allows leakage of intestinal contents into the abdominal cavity. Symptoms may include high fever, nausea and severe abdominal pain getting worse on movement. Intense vomiting may occur and result in dehydration. Perforation could cause peritonitis, which if not treated can cause almost immediate death (Medline Plus, 2007). Causes of perforation include a diverticular or cancerous lesion, colonoscopy or sigmoidoscopy (very rare), ischaemia of the bowel possibly caused by a strangulated hernia and surgically induced.

Strangulated hernia occurs when the blood supply to the bowel is cut off and may lead to ischaemia, necrosis and gangrene. Main symptoms are nausea, vomiting and severe pain.

Undiagnosed diarrhoea. There are many causes of diarrhoea (for example, colitis, small bowel disease, pancreatic, endocrine, infection, antibiotic therapy, drug induced) and it may lead to dehydration and electrolyte imbalance (Steele, 2007). Beware mistaking overflow for diarrhoea.

Undiagnosed rectal bleeding can have a number of causes, including haemorrhoids, anal fissure, proctitis, diverticular disease, colitis, polyps, ulceration or a life threatening malignancy. The type of blood (fresh or dark) and where seen (on the toilet paper on wiping or on the faeces) needs to be ascertained. Recent change in

bowel habit, unintentional weight loss, rectal bleeding, anaemia, increased mucus and wind not associated with any lifestyle changes may be due to malignancy, inflammation or ischaemia (Steele, 2007). An individual with any of these symptoms should visit their general practitioner, who will then refer onto the appropriate service for further investigation if required. See NICE guidance on colorectal cancer: *The diagnosis and management of colorectal cancer* (NICE, 2011).

Faecal impaction is a complication of constipation, and if not treated can cause an obstruction of the bowel. Macrogol 3350 with electrolytes, is licensed to treat faecal impaction and may need to be given in combination with rectal stimulants such as an enema. DRF may be appropriate for patients with impaction.

Autonomic dysreflexia (AD) is an abnormal sympathetic nervous system response to a noxious stimulus below the level of injury which can occur only in people with a spinal cord injury at level sixth thoracic vertebrae (T6) or above. Acute episodes may result in rapidly rising blood pressure with accompanying risk of brain haemorrhage and possible death (Kavchak-Keyes, 2000). Among susceptible individuals, 36 per cent report dysreflexic symptoms occasionally and nine per cent always when they conduct bowel management (Coggrave, 2008). The patient should be observed for symptoms of AD which may include flushing, sweating, chills, nasal congestion and headache while bowel care is being carried out, as acute AD may occur in response to digital interventions; however it is most likely to occur in response to ineffective bowel care due to withholding of essential interventions (Coggrave, 2008). Therefore it is important that all nurses in whatever care setting are aware of this condition and are aware of how it can be treated to reduce the risk of the above complications occurring. The signs and symptoms of AD are headache, flushing, sweating, nasal obstruction, blotchiness above the lesion and hypertension. The cardinal sign of acute AD is a rapidly developing severe headache. If this occurs DRF should be stopped, medical assessment undertaken and should be treated promptly (Coggrave, 2008).

Mapping SfH competences to this aspect of practice:

- prioritise individuals for further assessment, treatment and care EUSC07
- assess an individual's health status CHS39
- review presenting conditions and determine the appropriate intervention for an individual EUSC05
- receive requests for assistance, treatment or care GEN58.

9

Consent, confidentiality, chaperoning, privacy and dignity

Knowledge and understanding

You will need to know and understand:

- **how to obtain valid consent, that the individual has the ability to consent and cooperate and how to confirm that sufficient information has been provided on which to base this judgement.**

Within the constraints of this document it is not possible to cover all areas relating to consent. Therefore, the most important principles of consent are covered in relation to bowel care and consent. It is suggested that further reading in this area needs to be carried out and references to support this activity can be found at the end of the document.

Note: trust and dignity between the nurse and patient is essential for the right of all patients to achieve self-determination and autonomy.

Obtaining consent is essential before carrying out nursing care, treatment or procedures involving physical contact with a patient. Without consent, the care or treatment may be considered to be unlawful. Your employer – or you personally – could be sued for compensation by the patient if you have not obtained consent, even if your care or treatment was to the patient's benefit.

Consent may be **verbal, written** or **implied**. In all instances, you must record the type of consent obtained in the patient's nursing record. It is always best for the person actually treating the patient to seek the patient's consent. However, consent may be obtained on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

Your NHS trust or organisation may have a policy setting out when you need to obtain written consent. A signature on a consent form does not prove that consent has been obtained, although it would indicate that some discussion has taken place and is a record the patient's decision.

When obtaining consent, it must achieve three requirements to ensure it satisfies case law and is therefore deemed lawful and legal:

Requirement 1: *consent should be given by someone with the mental ability to do so.*

Requirement 2: *sufficient information should be given to the patient.*

Requirement 3: *consent must be freely given.*

You must respect and support people's rights to accept or decline treatment and uphold their right to be fully involved in decisions about their care, and be aware of the legislation regarding mental capacity (NMC, 2008; DH, 2001).

Mental Capacity Act 2005 Code of Practice (DOCA, 2007)

The five key principles of the act need to be taken into consideration when gaining consent from a patient.

1. A presumption of capacity – every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise.
2. Individuals must be supported to make their own decisions – a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
3. Unwise decisions – just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
4. Best interests – an act done or decision made under the Act for, or on behalf of, a person who lacks capacity, must be done in their best interests.
5. Least restrictive option – anything done for, or on behalf of a person who lacks capacity, should be the least restrictive of their basic rights and freedoms.

Adults with Incapacity (Scotland) Act 2000

All decisions made on behalf of an adult with impaired capacity must:

- benefit the adult
- take account of the adult's past and present wishes
- restrict the adult's freedom as little as possible while still achieving the desired benefit
- encourage the adult to use existing skills or develop new skills
- take account of the views of others with an interest in the adult's welfare.

Consent in emergency situations

Significant nursing interventions may take place in an emergency situation. The law is quite specific about the issue of consent in emergency situations: where treatment is required to safeguard the life or health of an individual, it is not a legal requirement that the patient's consent must be obtained. However the NMC (2008) states that:... you must be able to demonstrate that you have acted in someone's best interests if you have provided care in an emergency...

Confidentiality (DH, 2007a)

When obtaining consent, issues of confidentiality should be paramount – especially when dealing with the patient's wishes and beliefs if they do not want the information obtained to be shared with others.

All staff working in the NHS must meet the standards of the confidentiality within the NHS Code of Practice and accept these as within their terms of employment.

It is important that people are informed about how and why information is shared by those who will be providing their care, and that you must disclose information if you believe they may be at risk of harm (NMC, 2008).

Chaperoning (NHS Clinical Governance Support Team, 2005)

Knowledge and understanding

You will need to know and understand:

- **those who may accompany the individual (eg, carers and chaperones) and be present during the assessment and how to work with them.**

Patients should be informed that they have the right to request a chaperone when undergoing any procedure or examination or treatment. If a chaperone (whether formal or informal) cannot be provided, the patient must be informed and asked if they wish to continue with the procedure or examination. Their decision should be recorded in the patient records.

Where intimate procedures or examinations are required, you should be aware of any cultural, religious beliefs or restrictions the patient may have which prohibits this being done by a member of the opposite sex.

Mapping SfH competences to this aspect of practice:

- assess bladder and bowel dysfunction CC01
- obtain valid consent or authorisation CHS167
- enable individuals to make informed health choices and decisions PE1.

Privacy and dignity

Knowledge and understanding

You will need to know and understand:

- **how to manage the privacy and dignity of individuals in both conscious and unconscious states.**

Nurses need to identify the nature of support that the individual needs and respect their privacy, dignity, wishes and beliefs when working with them. In addition, nurses should help individuals who need assistance to prepare for any clinical activity in a manner which retains their dignity, and is in accordance with their personal beliefs and preferences (SfH, GEN4).

Consider the following in relation to the privacy and dignity of the individual (NHS, 2010):

- people and carers feel that they matter all of the time
- people experience care in an environment that encompasses their values, beliefs and personal relationships
- people's personal space is protected by staff
- people and carers experience effective communication with staff, which respects their individuality
- people experience care that maintains their confidentiality
- people's care ensures their privacy and dignity, and protects their modesty
- people and carers can access an area that safely provides privacy.

10

Communication

Knowledge and understanding

You will need to know and understand:

- **how to communicate clearly and coherently taking into account the needs of the individuals, selecting the most appropriate method of communication for that individual.**

Individuals with bowel dysfunction problems often feel stigmatised and embarrassed about their problem and because of this find it difficult to discuss with others. As a health care professional it is imperative to be empathetic and sensitive (NICE, 2007) to the feelings of these patients, so that they are able to discuss their symptoms freely without feeling judged or embarrassed. For this reason it is important to use different types of communication to ensure that the individual understands what is being conveyed to them. This includes giving the patient tools to help them describe their symptoms, for example using the British Stool type chart to describe their stool.

There are many different ways to communicate with individuals, depending on their needs, ability and preferences. The nurse needs to use appropriate body language, eye contact, and methods of listening that will actively encourage individuals to communicate.

Aspects to consider in relation to effective communication include:

- written format – leaflets, booklets
- audible format – adapt language, instructions
- visual format – diagrams, models, demonstration, photographs, products.

It is essential to develop rapport by using active and empathic listening skills and being non-judgmental.

Use appropriate language that allows the patient to understand, and avoid jargon. Communication should be in private, and with the least amount of distractions. Consider using interpreters when working with patients whose first language is not English, and audio or Braille when working with people who have visual impairment.

Mapping SfH competences to this aspect of practice:

- communicate effectively in a health care environment GEN97
- liaise between primary, secondary and community teams GEN44
- develop effective relationships with individuals SCDHSC0233
- provide clinical information to individuals CHS56
- manage information and materials for access by patients and carers PE2
- develop relationships with individuals that support them in addressing their health needs PE5.

Documentation

Knowledge and understanding

You will need to know and understand:

- **how to produce records and reports that are clear, comprehensive and accurate, and maintain the security and confidentiality of information.**

The Nursing and Midwifery Council (NMC, 2010) provides guidance on documentation which is clear and specific with regards to what should be recorded, by who, and when.

Good record keeping – whether at an individual, team or organisational level – has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information
- between members of the multi-professional health care team
- helping to identify risks, and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning
- helping to address complaints or legal processes.

The principles of good record keeping apply to all types of records, regardless of how these are held, and can include:

- handwritten clinical notes
- emails and letters to and from other health professionals
- laboratory reports, x-ray, printouts from monitoring equipment
- incident reports and statements, photographs, videos
- tape-recordings of telephone conversations, text messages.

Record keeping and good documentation is an integral part of nursing. It is a mark of a skilled and safe practitioner. Nurses should be aware that good documentation and record keeping helps protect the welfare of patients and themselves.

Documentation records should use terms that the patient can easily understand, and should not include any abbreviations, jargon, meaningless phrases, irrelevant speculation, offensive or subjective statements.

Practitioners have a duty to protect the confidentiality of the patient and patient record. The patient's documentation records should be factual, consistent, accurate and unambiguous. The record should be completed as soon as possible after the event has occurred, and the text should be clear and legible. It should be accurately dated, timed and signed, with the name printed alongside. If justifiable alterations or additions need to be made these should be dated, timed and signed clearly to the attributed named person; the original entry should still be legible.

Patients have the right to access records held about them, in line with local policy. Records can also be scrutinised by other professionals, if need be, to clarify certain issues.

Mapping SfH competences to this aspect of practice:

- determine a treatment plan for an individual CHS41
- develop clinical protocols for delivery of services CHS170
- monitor your own work practice GEN23
- capture and transmit information using electronic communication media GEN69
- monitor the condition of individuals SCDHSC0224
- develop models for processing new data and information in a health context HI5
- provide authorised access to records SS34.

Risk assessment

Knowledge and understanding

You will need to know and understand:

- the importance of including risk assessment within the wider assessment process, to identify high risk individuals with potentially life shortening conditions such as bowel/bladder cancer, systemic infection or skin breakdown because of incontinence.

Nurses need to be able to identify patients that are at risk of developing bowel dysfunction. It is vital to check for allergies – for example latex, soap (lanolin), phosphate and peanut (arachis oil enema) – before going ahead with procedures that involve these materials. Nurses should be competent at using risk assessment tools and questionnaires related to bowel dysfunction.

Individuals that may be at risk of developing bowel dysfunction include those suffering from or with:

- central neurological disease or trauma such as spinal cord injury, MS, Parkinson's disease, stroke
- eating disorders
- end-of-life care needs
- cognitive impairment or behavioural issues
- acute disc prolapse – cauda equina syndrome
- acquired brain injury
- history of abuse (sexual, physical)
- mobility issues
- prostatic obstruction/hypertrophy
- nutritional issues
- alcohol and drug dependency issues.

As well as:

- frail older people
- individuals in communal settings
- peri-natal/pregnant women
- women post-childbirth
- patients post-surgery
- critically-ill patients.

High risk bowel issues which may increase the complications associated with lower bowel dysfunction include:

- active inflammatory bowel disease

- acute diverticular disease/diverticulitis
- rectal pain
- rectal and anal sepsis, abscess and fistula
- recent radiotherapy to pelvic area
- recent rectal or anal surgery
- obvious rectal bleeding
- allergies
- autonomic dysreflexia
- anal tissue fragility
- inflamed and painful haemorrhoids
- anal fistula or fissure
- anal stenosis.

Risk assessment is essential when undertaking an invasive procedure such as administering an enema:

- risk awareness – understand what complications could occur when administering an enema
- risk assessment – consider risks prior to administering an enema; for example, has the patient had recent anal surgery?
- risk importance and priority – is the clinical need an emergency, have all other appropriate options been tried? Does the likely benefit of giving the enema outweigh the possible risks?
- risk identification – a phosphate enema may have more associated complications in certain patients such as the frail elderly
- risk likelihood and factors – the patient has dementia and is unable to consent
- risk severity – an elderly patient has poor renal function and administering a phosphate enema may induce hyperphosphatemia (HSU, 2008)
- risk prevention – staff competency
- risk avoidance – to avoid the risk completely the enema is not administered, but this must be weighed against the risks of not giving the enema
- risk reduction – use other rectal medication such as suppositories.

Mapping SfH competences to this aspect of practice:

- assess risks associated with health conditions CHS46
- plan inter-disciplinary assessment of the health and wellbeing of individuals CHS52.

13

Infection control (including *Clostridium difficile*) and care of the environment

Knowledge and understanding

You will need to know and understand:

- the relevant standard infection control precautions legislation and policies covering your area of work, as well as your own role and responsibilities, and the responsibilities of others.

Due to the extent of infection control aspects, it is not possible within the constraints of this document to discuss in depth. However nurses need to consider the following aspects of infection control, when caring for patients with bowel dysfunction:

- standard precautions for handling and disposing of any body fluid
- hand hygiene
- use of personal protective equipment
- care of the environment
- decontamination of equipment
- care of the patient with diarrhoea
- disposal of equipment and containment products.

Clostridium difficile infection

Clostridium difficile infection (*C.difficile*) is a significant cause of health care associated diarrhoea, and outbreaks are problematic for both patients and health care organisations. When certain antibiotics disturb the balance of bacteria in the gut, *Clostridium difficile* can multiply rapidly and produce toxins which cause illness and diarrhoea.

The Department of Health has produced high impact intervention care bundle guidance (DH, 2007b), which is available at <http://hcai.dh.gov.uk>

How to deal with the problem: Core guidance (HPA, 2009)

It is important that when a patient presents with diarrhoea, the possibility that it may have an infectious cause is considered. Patients with suspected potentially infectious diarrhoea should be isolated.

The Department of Health and the Health Protection Agency have produced 10 key recommendations for health care providers entitled *Clostridium difficile: how to deal with the problem* (2008) which can be downloaded at www.hpa.org.uk

Clinicians should apply the following SIGHT mnemonic protocol when managing suspected potentially infectious diarrhoea such as CDI:

- | | |
|----------|---|
| S | Suspect that a case may be infective where there is no clear alternative cause for diarrhoea. |
| I | Isolate the patient and consult with the infection control team while determining the cause of diarrhoea. |
| G | Gloves and aprons must be used for all contacts with the patient and their environment. |
| H | Hand washing with soap and water should be carried out before and after contact with the patient and the patient's environment. |
| T | Test the stool for toxin, by sending a specimen immediately. |

Mapping SfH competences to this aspect of practice:

- minimise the risk of spreading infection by cleaning, disinfecting and maintaining environments IPC1
- perform hand hygiene to prevent the spread of infection IPC2
- clean, disinfect and remove spillages of blood and other body fluid to minimise the risk of infection IPC3
- minimise the risk of spreading infection by cleaning, disinfecting and storing care equipment IPC4
- minimise the risk of exposure to blood and body fluids while providing care IPC5
- use personal protective equipment to prevent the spread of infection IPC6
- minimise the risks of spreading infection when storing and using clean linen IPC12
- minimise the risk of infection when transporting and storing health and care related waste IPC8
- minimise the risks of spreading infection when removing used linen IPC9
- provide guidance, resources and support to enable staff to minimise the risks of spreading infection IPC13.

- people experience care in a tidy and well maintained area
- people experience care in a consistently clean environment
- people feel confident that infection control precautions are in place
- patients' personal environment is managed to meet their individual needs
- patients' care is supported by effective use of linen and furnishings.

Mapping SfH competences to this aspect of practice:

- maintain health, safety and security practices within a health setting GEN96
- prepare individuals for health care activities GEN4
- support individuals undergoing health care activities GEN5
- manage environments and resources for use during health care activities GEN6
- monitor and manage the environment and resources during and after clinical/therapeutic activities GEN7
- care for individuals using containment products CC08
- enable individuals to effectively evacuate their bowels CC09.

Care of the environment

Knowledge and understanding

You will need to know and understand:

- **the methods of enabling the individual to be as comfortable as possible and maintaining their dignity and privacy, given the constraints of the particular bowel emptying technique and the setting.**

Nurses need to consider the following in relation to the care environment, to ensure that it meets the individual's needs and preferences (DH, 2007c):

- people can access the care environment easily and safely
- people feel comfortable, safe, reassured, confident and welcome

Health care assistants

Health care assistants (HCAs) are an important part of the workforce in delivering patient care within health care. The following statements consider some aspects of the role of the HCA in lower bowel care, and are not comprehensive. HCAs may undertake a range of lower bowel care procedures, following assessment by a qualified competent nurse, if the HCA:

- has been deemed competent in the particular lower bowel care task
- the qualified nurse agrees to delegate that lower bowel care task to that particular HCA, and that the patient consents
- local policy permits the delegation of these tasks.

It is acceptable for the following procedures or tasks to be undertaken by a competent HCA on a named patient basis:

- DRE
- DRF
- digital rectal stimulation (DRS)
- wash a patient with a diarrhoea containment product in situ
- move a patient with a diarrhoea containment product in situ (manual handling)
- be aware of, and use, a variety of lower bowel care support equipment
- change a diarrhoea containment bag
- insert an anal plug
- insert a glycerine or other evacuatory suppository, where this is deemed to be low risk
- administer an enema, where this is deemed to be low risk
- obtain a specimen of faeces to send for culture.

HCAs have an individual responsibility to ensure they feel confident and competent in the knowledge and skills of practice in line with local guidelines, procedures and policies.

Developing competence in lower bowel care

The HCA should be actively encouraged to gain clinical development in all aspects of lower bowel dysfunction. The HCA should acquire knowledge, understanding and skills relating to the supervised delivery of lower bowel care, including:

- an understanding of the anatomy of the lower gastrointestinal tract
- the indications, exclusions and contraindications for DRE and DRF
- common complications and solutions associated with lower bowel dysfunction
- legal aspects of lower bowel care provision
- skin care when and how to apply products
- infection control, hand hygiene, personal protective equipment (PPE).

Acceptable performance criteria for clinical practice will be met through observation and supervision, which should include being supervised by competent qualified staff. Such supervision should be documented and counter signed by the supervisory nurse in some form of competency document kept by the trust as well as within the HCA's personal portfolio.

In addition:

- the importance of accurate documentation relating to lower bowel dysfunction is vital
- annual half-day study sessions should be considered as mandatory
- HCAs needs to be aware of their limitations to practice (difficult/abusive patients)
- HCAs should actively report risks and untoward incidents to qualified staff in line with local policy guidelines.

This will ensure competency in line with NOS to meet patient service needs.

HCAs should inform their immediate line manager if they feel they are not competent to undertake any form

of lower bowel care, so additional training needs can be identified and be facilitated at local level.

Programmes of learning for HCAs, in line with the NOS related to all aspects of lower bowel dysfunction, should be facilitated by competent qualified staff at local levels. To ensure that the patient's care actively achieves social continence status and promotes the individual patients privacy, dignity and protects their modesty, such programmes of learning should include consideration of physical, social, sexual and physiological aspects of lower bowel dysfunction. However the assessment of the patient remains to be the remit of the registered practitioner.

For further NMC guidance on delegating to non-regulated health care staff visit www.nmc-uk.org

Legislation, policy and good practice

Knowledge and understanding

You will need to know and understand:

- **how to apply legislation, policy and good practice, the current international, European, UK and national legislation, guidelines and local policies, protocols and procedures which affect your work practice in relation to bowel care.**

In essence the above statement relates to key documents and publications which influence this specific aspect of care, and outline your areas of responsibility.

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Appendix 1

Procedure for digital rectal examination (DRE)

- Explain the procedure to the patient, the potential risks, obtain informed consent and document. Once consent is obtained if the patient requests you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone present.
- Give the patient the opportunity to empty their bladder.
- Ensure privacy and dignity is maintained at all times.
- If the patient has a spinal injury (SCI) above T6 observe the patient throughout the procedure for signs of autonomic dysreflexia (described earlier in the document).
- Wash hands and put on disposable apron and gloves.
- Ask/assist patient to lower any clothing to knees and ask the patient to ideally lie in the left lateral position with knees flexed so that the perianal area can be easily visualised. The left side is preferred as it allows DRE to follow the natural anatomy of the bowel but it is not essential.
- Place protective pad under the patient, and cover the legs/area not to be exposed.
- Inform the patient that you are to begin and that you will be looking and examining the outer and internal area.
- Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood.
- Next palpate the perianal area by starting at the 12 o'clock position moving clockwise to 6 o'clock and then returning to 12 o'clock and moving to 6 o'clock anticlockwise, feeling for irregularities, indurations, tenderness or abscess.
- Lubricate a gloved index finger, part the buttocks and gently insert into the anus to avoid trauma to the anal mucosa, noting tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient feels any pain ensure that they are happy for you to continue with the procedure. It may be easier to ask the patient to talk or breath out to prevent spasm or difficulty on insertion. Also work with the anal reflex by putting your finger on the anus gently and wait a few second this will allow the anus to contract and then relax.
- Sweep clockwise and then anticlockwise, palpate for irregularities internally. Noticing the presence of any tenderness, presence and consistency of faecal matter (an assessment of its consistency according the Bristol Stool Form Chart) and any lesions.
- You also assess the external sphincter tone by asking the patient to squeeze and hold. Also ask the patient to push down to assess for relaxation on straining.
- Prostate and advance pelvic floor assessment may also take place at this point if competent to do so.
- Remove finger, clean perianal area of any gel/ faecal matter. Remove gloves and apron disposing of them appropriately then wash your hands.
- Ensure patient's privacy, dignity and comfort at all times.
- Wash hands and allow the patient to dress in private, unless they need assistance.
- Explain your findings and plan.
- Document all observations, findings and actions. Consider onward referral to another health care professional if there were any concerns on examination.

Appendix 2

Procedure for digital removal of faeces (DRF) (MASCIP, 2009)

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can easily be visualised.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). It should also be considered if this is undertaken as an acute intervention. This requires five-ten minutes to take effect and lasts up to 90 minutes. Note that long-term use should be avoided due to systemic effects (BNE, 2008).
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- If stool is a solid mass, push finger into centre, split it and remove small sections until none remain. If stool is in small separate hard lumps remove a lump at a time. Great care should be taken to remove stool in such a way as to avoid damage to the rectal mucosa and anal sphincters – in other words do not over-stretch the sphincters by using a hooked finger to remove large pieces of hard stool which may also graze the mucosa. Using a hooked finger can lead to scratching or scoring of the mucosa and should be avoided.
- Where stool is hard, impacted and difficult to remove other approaches should be employed in combination with digital removal of faeces. If the rectum is full of soft stool continuous gentle circling of the finger may be used to remove stool: this is still digital removal of faeces.
- During the procedure the person delivering care may carry out abdominal massage.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matter in an appropriate receptacle as it is removed, and dispose of it and any other waste in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Scale (Heaton, 1993).
- Record and report abnormalities.

Appendix 3

Procedure for digital rectal stimulation (DRS) (MASCIP, 2009)

- Explain the procedure to the patient (if necessary) and obtain consent. Even if the patient consents to the procedure, if they request you to stop at any time, you must stop.
- The patient should be asked if they wish to have a chaperone.
- Ensure a private environment.
- If the patient has a spinal cord injury (SCI) observe the patient throughout the procedure for signs of autonomic dysreflexia.
- When carrying out this procedure the patient should ideally be lying in a lateral position, usually on the left, so that the anal area can easily be viewed.
- Place protective pad under the patient if appropriate.
- Wash hands, put on two pairs of disposable gloves and an apron.
- If the patient suffers local discomfort (or symptoms of autonomic dysreflexia) during this procedure local anaesthetic gel may be instilled into the rectum prior to the procedure (Furasawa, 2008; Cosman, 2005). This requires five-ten minutes to take effect and lasts up to 90 minutes. Note that long term use should be avoided due to systemic effects (BNF, 2008).
- Lubricate gloved finger with water soluble gel.
- Inform patient you are about to begin.
- Insert a single, double-gloved, lubricated finger slowly and gently into rectum.
- Turn the finger so that the padded inferior surface is in contact with the bowel wall.
- Rotate the finger in a clockwise direction for at least 10 seconds, maintaining contact with the bowel wall throughout.
- Withdraw the finger and await reflex evacuation.
- Repeat every five-ten minutes until rectum is empty or reflex activity ceases.
- Remove soiled glove and replace, relubricating as necessary between insertions.
- If no activity occurs during the procedure, do not repeat it more than three times. Use digital removal of faeces (DRF) if stool is present in the rectum.
- Once the rectum is empty on examination, conduct a final digital check of the rectum after five minutes to ensure that evacuation is complete.
- Place faecal matter in an appropriate receptacle as it is removed and dispose of it, and any other waste, in a suitable clinical waste bag.
- When the procedure is completed, wash and dry the patient's buttocks and anal area and position comfortably before leaving.
- Remove gloves and apron and wash hands.
- Record outcomes using the Bristol Scale (Heaton, 1993).
- Record and report abnormalities.

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Useful resources and organisations

Alzheimer's Society

Devon House, 58 St. Katherine's Way, London, E1W 1JX
Tel: 020 7423 3500, www.alzheimers.org.uk

Association of Continence Advice (ACA)

Fitwise Management Ltd., Blackburn House, Rehouse Road, Seafield, Bathgate, West Lothian, EH47 7AQ
Tel: 01506 811077, www.aca.uk.com

Bladder and Bowel Foundation

71 Duke Street, Mayfair, London, W1K 5NY,
Tel: 0845 3450165,
www.bladderandbowelfoundation.org

British Toilet Association

PO Box 17, Winchester, Hampshire, SO23 9WL
Tel: 01962 850277, www.britloos.co.uk

Coloplast Limited

Peterborough Business Park, Peterborough, PE2 6FX
01733 292000, www.charterhealthcare.co.uk

CORE

3 St Andrews Place, London, NW1 4LB
Tel: 020 7486 0341, www.corecharity.org.uk

RCN Continence Care Forum

Royal College of Nursing, 20 Cavendish Square, London, W1G 0RN
Tel: 020 7409 3333, www.rcn.org.uk

Disabled Living Foundation

380-384 Harrow Road, London, W9 2HU
Tel: 0870 770 3246, www.dlf.org.uk

Help the Aged

207-221 Pentonville Road, London, N1 9UZ
Tel: 020 7278 1114, www.helptheaged.org.uk

Hollister

Hollister Ltd., Rectory Court, 42 Broad Street, Wokingham, Berkshire, RG40 1AB
Tel: 0118 989 5000, www.hollister.com

Multiple Sclerosis Society

MS National Centre, 372 Edgware Road, London, NW2 6ND
Tel: 020 8438 0700, www.msociety.org.uk

National Association for Colitis and Crohn's Disease

4 Beaumont House, Sutton Road, St. Albans, Hertfordshire, AL1 5HH
Tel: 0845 130 2233, www.nacc.org.uk

Norgine Pharmaceuticals Limited

Chaplin House, Widewater Place, Moorhall Road, Harefield, Middlesex, UB9 6NS
Tel: 01895 453710, www.norgine.com

Parkinson's Disease Society

PDS National office, 215 Vauxhall Bridge Road, London, SW1V 1EJ
Tel: 020 7931 8080, www.parkinsons.org.uk

Promocon

Redbank House, St. Chad's Street, Cheetham, Manchester, M8 8QA
Tel: 0161 832 3678, www.promocon.co.uk

RADAR

12 City Forum, 250 City Road, London, EC1V 8AF
Tel: 020 7250 3222, www.radar.org.uk

Spinal Injuries Association (SIA)

SIA House, 2 Trueman Place, Oldbrook, Milton Keynes, MK6 2HH
Tel: 0845 678 6633, www.spinal.co.uk

The Gut Trust

Unit 5, 53 Mowbray Street, Sheffield, S3 8EN
Tel: 0114 272 3253, www.theguttrust.org

Clinical skills Ltd

114 Park Road, Chiswick, London W4 3HP
Tel: 020 8995 3336, www.clinicalskills.net



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