GUIDELINES FOR DIGITAL RECTAL EXAMINATION AND DIGITAL REMOVAL OF FAECES & THE USE OF RECTAL IRRIGATION

Berkshire Healthcare

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Re-issued: October 2016
Review Date: October 2018
Version: 4
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<th>Policy Number:</th>
<th>CCR122</th>
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<td>Guidelines For Digital Rectal Examination and Digital Removal of Faeces &amp; the use of Rectal Irrigation</td>
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<tr>
<td>Category:</td>
<td>Clinical Care &amp; Risk</td>
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<td>Distribution Areas:</td>
<td>Berkshire Healthcare Community Nursing Staff</td>
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<tr>
<td>Designated Lead:</td>
<td>Continence Service Manager</td>
</tr>
<tr>
<td>For policy information:</td>
<td>Policy Administration Berkshire Healthcare 2nd Floor Fitzwilliam House Skimped Hill Lane Bracknell RG12 1BQ 01344 415623</td>
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POLICY DEVELOPMENT

CCR122 - GUIDELINES FOR DIGITAL RECTAL EXAMINATION AND DIGITAL REMOVAL OF FAECES & THE USE OF RECTAL IRRIGATION

History:

Version 4:  Title changed to digital removal of faeces rather than manual removal which is more reflective of the procedure. Updated training requirements within Berkshire Healthcare. Changes to the accountability of the HCA as set out in CCR138 Delegation of Procedures to Non-Registered Healthcare Workers in the Community.

Version 3:  The role of the Healthcare Assistant included. Referenced to Hand Hygiene Policy. The Policy advises how to contact the relevant manufacturer for up-to-date instructions/guidance or the Continence Service. The Bristol Stool Chart included as Appendix 1. References and job titles updated.

Version 2:  Policy re-issued August 2012. Section 4.2 reviewed and updated.

Version 1:  Integrated CHS policies.

Designated Leads:  Continence Service Manager

Policy Consultants:  District Nursing Teams & Continence Nurse Specialists

Endorsed by:  Policy Scrutiny Group – 16th September 2016

This policy has been assessed for compliance with CQC Fundamental Standards.
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1. INTRODUCTION

The purpose of this document is to provide research based guidelines on Digital Rectal examination, the digital removal of faeces and the use of rectal irrigation (when appropriate) in adults. These guidelines do not include the care of children. This document should be read in conjunction with Berkshire Healthcare Policies:

- Hand Hygiene (ICC001/CCR032).
- Delegation of Procedures to Non-Registered Healthcare Workers in the Community (CCR138).
- Consent to Examination and/or Treatment (CCR035).

2. TRAINING

These guidelines are intended for use by Community Staff employed by Berkshire Healthcare. Nurses are required to maintain their own professional knowledge and competence (NMC 2015). It is the responsibility of the individual nurse to access training to ensure that he or she is competent to practice (see Learning and Development Prospectus available on the intranet).

Only a competent practitioner should carry out the procedure. To ensure competence, the nurse should have successfully completed a Digital Rectal Examination course based on the RCN (2012) publication. This can be booked through the SLATE via the Learning and Development Team. The Learning & Development department will ensure records of attendance for training are entered onto the Electronic Staff Record (ESR), with periodic reports being generated as required to monitor compliance levels. Staff who have attended competency based training from other employers can request to have their training recorded on their ESR records by producing the evidence of their training and competence to their manager. Their manager will need to inform L&D of their agreement of the recording of this training competence.

3. THE ROLE OF THE HEALTHCARE ASSISTANT

Healthcare Assistants (HCA’s) can undertake a range of bowel care procedures on a named patient basis following training and competency assessment by a qualified competent nurse and with the patients consent. The HCA can attend the same training as qualified nurses in order to support their competence. This can be booked through the learning and development team. The HCA does have individual responsibility to ensure they are confident and competent to undertake the task (refer to policy CCR138 Delegation of Procedures to Non-Registered Healthcare Workers in the Community).

4. CONSENT

All rectal interventions are invasive procedures and as such the patients consent is required in line with CCR035 Consent to Examination and/or Treatment Policy. This should be clearly documented within the patient's notes and the patient should be offered a chaperone for the procedure. Where the patient lacks capacity to consent to the procedure, the provisions of the Mental Capacity Act 2005 should be followed in line with CCR035 Consent to Examination and/or Treatment Policy.
5. **ASSESSMENT**

When a patient presents with a bowel dysfunction, for example, constipation, diarrhoea or faecal incontinence, the bowel care pathway should be followed to ensure that the patient receives a full holistic assessment based on current best practice. [https://www.beatingbowelcancer.org/your-care-pathway](https://www.beatingbowelcancer.org/your-care-pathway)

5.1 **Digital Rectal Examination**

A Digital Rectal Examination may be used as part of the assessment process. It should **not** be used as a sole investigation for the diagnosis and treatment of constipation. Digital Rectal Examination can be used to establish the following:

- The presence of faecal matter in the rectum; the amount & consistency.
- Anal tone and the ability to initiate a voluntary contraction and to what degree and teach pelvic floor exercises.
- Assess anal pathology.
- Anal and rectal sensation.
- The need for and effects of rectal medication in certain circumstances.
- The need for digital removal of faeces/ digital removal of faeces and evaluating bowel emptiness.
- The outcome of rectal and colonic washout or irrigation if appropriate.
- The need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex.

(Taken from the RCN guidelines 2012)

In addition Specialist Continence Nurses/ Physiotherapists can use DRE for the following subject to specialist training and achieving competency at level 4:

- Anal manometry.
- Placement of rectal probes for urodynamics, electrical stimulation or biofeedback.
- Prostate assessment (RCN 2008).

Care must be taken at all times to ensure that the patient’s privacy and dignity are maintained throughout the procedure.

5.2 **Treatment of Faecal Impaction**

First line treatment of faecal impaction should be using oral medication. Only when oral medication is not effective or is contra-indicated should suppositories and enemas be used.

When patients are under the care of an acute Trust and have a detailed care plan requiring deviation from this guidance. The Continence Team should be contacted for advice and support.

Staff should be trained and competent to administer rectal medication when this is required and the clinical need for such intervention should be reviewed at least every 6 months.

6. **DIGITAL REMOVAL OF FAECES**

This should be considered as a last resort when all other treatments have failed. It may be undertaken in the following circumstances:
• When all other bowel emptying methods have failed or are inappropriate.
• When faecally impacted/ loaded.
• When defecation is incomplete.
• When there is an Inability to defecate.
• When there is neurogenic bowel dysfunction including patients with spinal cord injury.

(Taken from the RCN guidelines 2012)

For guidelines outlining the practical procedure, please refer to Kyle et al. (2008)

6.1 Observations when performing digital removal of faeces

It is expected that digital removal of faeces will only be performed as part of ongoing bowel care and not as an acute intervention. The following observations should be performed as part of ongoing care when manually removing faeces.

• Pulse should be measured prior to the procedure
• If the patient has a spinal cord injury then a baseline blood pressure recording should be included within the patient notes and reviewed 12 monthly or more frequently if deemed clinically necessary.
• If the patient has a spinal cord injury, then observe for the signs and symptoms of autonomic dysreflexia, (such as headache, flushing, sweating, hypertension, bradycardia)
• Stool consistency
• Observe for signs of distress, pain, discomfort, bleeding and collapse

(Taken from the RCN guidelines 2012)

6.2 Exclusions and contra-indications

Nurses should not undertake a DRE or digital removal of faeces if:

• There is a lack of consent from the patient (refer to CCR035 Consent to Examination and/or Treatment Policy).
• When medical instructions have stated that these procedures should not take place, for example when a patient has been diagnosed with cancer of the bowel.
• They have had recent rectal surgery.

(RCN 2012)

6.3 Circumstances when extra care is required

Health Care Professionals should exercise caution when the following apply:

• Active inflammation of the bowel, e.g. Crohn’s disease, ulcerative colitis.
• Recent radiotherapy to the pelvic area.
• Rectal or anal pain.
• Recent rectal surgery or trauma.
• Tissue fragility & loss of muscle tone.
• Rectal bleeding.
• Known history of abuse.
• Spinal cord injury (due to autonomic dysreflexia).
• Patient gains sexual satisfaction from the procedure.

(RCN 2012)
If in doubt as to whether the procedure should be performed, staff members should discuss the issues with the multi-disciplinary team and the patient. The Continence Advisory Service is always available for advice and support in these situations.

7. **RECTAL IRRIGATION**

Rectal irrigation should not be a first choice treatment option for patients. Digital Rectal Examination should also be performed prior to the first irrigation and documented to check there is no obstruction, that the anus is not stenosed and that there are not any painful ano-rectal conditions (such as anal fissure).

7.1 **Contraindications**

It is important to be aware that Rectal Irrigation is not suitable for all patients and there are certain conditions that may contraindicate or prohibit its use.

7.2 **Absolute contra-indications (irrigation should not be used)**

- Acute active inflammatory bowel disease.
- Known obstructing rectal or colonic mass.
- Rectal or colonic surgical anastomosis within the last 6 months.
- Severe cognitive impairment (unless carer available to supervise/administer).

7.3 **Additional care and close monitoring**

Some types of patients may require additional supervision or monitoring, at least until it is clear that irrigation is not producing any problems. This will depend on the judgement of the assessing professional, but may include;

- Spinal cord injury at or above T6. Monitor for autonomic dysreflexia until it is clear that the technique is well tolerated and does not provoke autonomic dysreflexia.
- Unstable metabolic conditions (frail, renal disease or liver disease; may need to measure electrolytes and possibly use saline rather than water for irrigation).
- Inability to perform the procedure independently or comply with the protocol in the absence of close involvement of carers (e.g., due to physical disability, cognitive impairment, major mental/emotional disorder). Experience to date with irrigation by a carer suggests that it is no more problematic than self-irrigation for physically disabled individual.

7.4 **Relative contra-indications (use only after careful discussion with a relevant medical practitioner)**

- Pregnant or planning pregnancy (women).
- Active perianal sepsis.
- Diarrhoea.
- Anal fissure.
- Large Haemorrhoids that bleed easily.
- Faecal impaction (clear if possible before starting irrigation).
- Past pelvic radiotherapy which has caused bowel symptoms.
- Known severe diverticular disease.
• Use of rectal medications for other diseases.
• Congestive cardiac failure.
• Anal surgery within the last 6 months.

7.5 Using Rectal Irrigation

Wherever possible it is usual to teach the patient to perform his/her own irrigation independently. However, carers and healthcare professionals can be taught how to do this procedure for patients. The procedure should be fully explained to the patient before it is carried out for the first time. Dependant on which system is used, up to date educational literature is available from the specific manufacturers. Additional support can be provided through the Continence Advisory Service.

If the patient is taking laxatives before the procedure, it is usually prudent to continue these until the irrigation routine is established. Once established the Health Professional can review the success of rectal irrigation, continuation of oral laxatives may be required long term but should be reviewed at least 6 monthly.

All spinal cord injured patients with an injury at or above T6 MUST be accompanied for their first two procedures and observed for signs of autonomic dysreflexia. Patients known to experience dysreflexia should have medication to hand in case it is needed.

Occasionally it may be judged that verbal instruction and handling of the equipment is sufficient, with the patient then using the equipment independently and alone.

7.6 Record Keeping

When carried out by a Health Professional, record the procedure in the patient’s notes, including the date, time of irrigation, the make, expiry date and batch number of the rectal catheter used, the result of the irrigation and any complications.

It is also essential to keep accurate records which should include:

• The reasons for selecting irrigation for this patient
• Discussions held with the patients about risks and benefits
• Information and instructions given to the patients and carers
• Patient consent to use irrigation
• Any adverse events reported
• Plans for follow-up and monitoring (suggested to be 6 monthly clinical contact if patient performing procedure themselves)

7.7 Troubleshooting

Please refer to the rectal irrigation procedure, or the continence advisory service.

8. REFERENCES


Royal College of Nursing (2012) Management of Lower Bowel function, including DRE & DRF. RCN Guidance for Nurses, London RCN.

9. ASSOCIATED BERKSHIRE HEALTHCARE DOCUMENTATION

CCR095 Privacy, Dignity & Respect Policy.
CCR035 Consent to Examination and/or Treatment Policy.
ICC001/CCR032 Hand Hygiene Policy.
CCR138 Delegation of Procedures to Non-Registered Healthcare Workers in the Community.
## Bristol Stool Chart

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on the surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces. <strong>Entirely Liquid</strong></td>
</tr>
</tbody>
</table>
 COMMENTS / FEEDBACK (This form can be photocopied as needed)


Name __________________________________ Date __________________

Address _______________________________________________________

Return comments for consideration three months prior to review date to the designated policy lead or the Governance Administration Manager, 2nd Floor, Fitzwilliam House, Skimped Hill Lane, Bracknell, RG12 1BQ. Tel: 01344 415623.

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General comments:
Equality Analysis – Template
‘Helping you deliver person-centred care and fair employment’

1. **Title of policy/ programme/ service being analysed**
   To ensure patient safety by providing guidelines for staff on the safe practice of digital rectal examination, digital removal of faeces and rectal irrigation.

2. **Please state the aims and objectives of this work and what steps have been taken ensure that the Trust has paid due regard to the need to eliminate discrimination, advance equal opportunities and foster good relations between people with protected characteristics.**
   District Nurses, Ward Staff, Continence Team.

3. **Who is likely to be affected? e.g. staff, patients, service users**
   District Nurses, Ward Staff, Continence Team.

4. **What evidence do you have of any potential adverse impact on groups with protected characteristics?**
   Include any supporting evidence e.g. research, data or feedback from engagement activities

<table>
<thead>
<tr>
<th><strong>4.1 Disability</strong></th>
<th>People who are learning disabled, physically disabled, people with mental illness, sensory loss and long term chronic conditions such as diabetes, HIV)</th>
<th>Consider building access, communication requirements, making reasonable adjustments for individuals etc</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4.2 Sex</strong></td>
<td>Men and Women</td>
<td>Consider gender preference in key worker, single sex accommodation etc</td>
</tr>
<tr>
<td><strong>4.3 Race</strong></td>
<td>People of different ethnic backgrounds, including Roma Gypsies and Travelers</td>
<td>Consider cultural traditions, food requirements, communication styles, language needs etc</td>
</tr>
<tr>
<td><strong>4.4 Age</strong></td>
<td>This applies to people over the age of 18 years. This can include safeguarding, consent and child welfare</td>
<td>Consider access to services or employment based on need/merit not age, effective communication strategies etc</td>
</tr>
<tr>
<td><strong>4.5 Trans</strong></td>
<td>People who have undergone gender reassignment (sex change) and those who identify as trans</td>
<td>Consider privacy of data, harassment, access to unisex toilets &amp; bathing areas etc</td>
</tr>
<tr>
<td><strong>4.6 Sexual orientation</strong></td>
<td>This will include lesbian, gay and bisexual people as well as heterosexual people.</td>
<td>Consider whether the service acknowledges same sex partners as next of kin, harassment, inclusive language etc</td>
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</tbody>
</table>

No adverse event identified.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.7</td>
<td>Religion or belief</td>
<td>Includes religions, beliefs or no religion or belief. Consider holiday scheduling, appointment timing, dietary considerations, prayer space etc. No adverse event identified.</td>
</tr>
<tr>
<td>4.8</td>
<td>Marriage and Civil Partnership</td>
<td>Refers to legally recognised partnerships (employment policies only). Consider whether civil partners are included in benefit and leave policies etc. No adverse event identified.</td>
</tr>
<tr>
<td>4.9</td>
<td>Pregnancy and maternity</td>
<td>Refers to the pregnancy period and the first year after birth. Consider impact on working arrangements, part-time working, infant caring responsibilities etc. No adverse event identified.</td>
</tr>
<tr>
<td>4.10</td>
<td>Carers</td>
<td>This relates to general caring responsibilities for someone of any age. Consider impact on part-time working, shift-patterns, options for flexi working etc. No adverse event identified.</td>
</tr>
<tr>
<td>4.11</td>
<td>Other disadvantaged groups</td>
<td>This relates to groups experiencing health inequalities such as people living in deprived areas, new migrants, people who are homeless, ex-offenders, people with HIV. Consider ease of access, location of service, historic take-up of service etc. No adverse event identified.</td>
</tr>
</tbody>
</table>

5 Action planning for improvement

5.1 Please outline what mitigating actions have been considered to eliminate any adverse impact?

5.2 If no mitigating action can be taken, please give reasons.

5.3 Please state if there are any opportunities to advance equality of opportunity?

An Equality Action Plan template is appended to assist in meeting the requirements of the general duty.

Sign off

Name of person who carried out this analysis: Michelle Hunt, Continence Service Manager

Date analysis completed: August 2016

Date analysis was approved by responsible Director: Ratified by the Safety, Experience & Clinical Effectiveness Group on 4th October 2016