The Royal College of Nursing (RCN) has produced clear guidelines for nurses working with adults in their documentation “Digital rectal examination and manual removal of faeces” RCN (2000). This bowel management policy sets out the professional and legal background against which all nurses are required to act. Many nurses are confused about the professional and legal aspects of digital rectal examination (DRE) and manual removal of faeces.

Because of the invasive nature of these procedures, and fears of accusations of abuse, some nurses have been uncertain about whether or not they should go ahead with these procedures, particularly when working out in the community. It is important that employers understand these fears and provide full, evidence based training so that nurses feel confident and competent to undertake these procedures when necessary.

With advances in oral, rectal and surgical treatments in recent years, the need to use DRE and manual removal of faeces has reduced but in specific circumstances, these procedures remain part of a bowel management routine.
VERSION CONTROL

Document Location

Oxleas NHS Foundation Trust Intranet | See under Bexley Community Provider Services

Change History

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Responsibility for distribution of this document

Director of Bexley Community Provider Services

Aim:
The aim of this policy is to ensure all adult community nursing staff are provided with research based best practice when providing bowel care for Bexley clients.

Links with other Policies:
- Marsden Manual clinical nursing procedures 6th Ed
- Infection Control policy
- Bowel Dysfunction Assessment form
- Consent Policy
- Record Keeping Policy

Audit / Monitoring:
- A yearly audit of this policy will be undertaken
- Policy to be reviewed yearly in the first year and then three yearly unless otherwise indicated

Content:

1. Introduction
2. Who should undertake DRE & manual removal of faeces
3. Mandatory training
4. When should nurses undertake DRE
5. Allergy
6. When should nurses undertake manual removal of faeces
7. Sensitivities around these procedures
8. Spinal cord lesion and autonomic dysreflexia
9. Circumstances when extra care is required
10. What to look for when observing the perianal and perineal area
11. Exclusions and contra-indications
12. Manual removal of faeces as an acute intervention
15. Digital stimulation
16. Constipation and prescribing rectal medication for constipation

References
Further reading
Useful contacts
1. Introduction:

The Royal College of Nursing (RCN) has produced clear guidelines for nurses working with adults in their documentation “Digital rectal examination and manual removal of faeces” (RCN, 2000). This bowel management policy sets out the professional and legal background against which all nurses are required to act. Many nurses are confused about the professional and legal aspects of digital rectal examination (DRE) and manual removal of faeces.

Because of the invasive nature of these procedures, and fears of accusations of abuse, some nurses have been uncertain about whether or not they should go ahead with these procedures, particularly when working out in the community. It is important that employers understand these fears and provide full, evidence based training so that nurses feel confident and competent to undertake these procedures when necessary.

With advances in oral, rectal and surgical treatments in recent years, the need to use DRE and manual removal of faeces has reduced but in specific circumstances, these procedures remain part of a bowel management routine.

2. Consent:

Obtaining consent is an important and necessary part of good clinical practice. It is accepted professional practice that trust and dignity between the nurse and patient is maintained. Obtaining the patient’s consent for care and treatment affirms their right to self-determination and autonomy. Consent is also the legal means by which the patient gives a valid authorisation for treatment or care. For legal and professional reasons, nurses require consent before carrying out any treatment.

Consent may be verbal, written or implied and must be recorded in patient notes for every episode of care.

3. Who should undertake DRE and manual removal of faeces:

Essential knowledge and skills: A qualified nurse who can demonstrate professional competence to the level determined by the NMC in its Code of Professional Conduct (NMC, 2002) and the Scope of Professional Practice (UKCC, 1992). This requires registered nurses to maintain and improve their professional knowledge and competence, to acknowledge any limitations in their knowledge and competence and to decline any duties or responsibilities unless they are able to perform them in a safe and skilled manner.

A qualified nurse who has undergone the appropriate training and can demonstrate competence to this professional level can delegate these procedures to patients/carers as appropriate, ensuring their competence is assessed reviewed and documented as necessary.

The NMC has a code of professional conduct which all nurses are required to follow. The code states "As a registered nurse, midwife or health visitor, you are personally accountable for your practice” The NMC’s Scope of Professional Practice (UKCC, 1992) lays accountability on the individual practitioner.
Under no circumstances, should nurses undertake a digital rectal examination (DRE) or manual removal of faeces unless they have undertaken the recommended training and deemed competent to do so. It is the nurse’s responsibility to inform their manager if they feel incompetent. Managers must be informed of specific training staff require to remain competent to undertake these procedures.

4. Mandatory training:

All qualified staff must attend training for DRE and manual removal of faeces provided by the trust. They will then undertake supervised practice and be signed competent to undertake these procedures (appendix 1)

5. When should nurses undertake DRE:

DRE may be used as part of a nursing assessment, providing the nurse has received the training provided by the Trust. DRE would be used in these circumstances to establish the presence of stool in the rectum. Following assessment, and decision on appropriate intervention, that may include manual removal of faeces.

In summary DRE may be used to establish the following:

- the presence of faecal matter in the rectum, the amount and consistency
- anal tone and the ability to initiate a voluntary contraction and to what degree
- anal/rectal sensation
- the need for and effects of rectal medication in certain circumstances.
- the need for manual removal of faeces and evaluating bowel emptiness
- the outcome of rectal/colonic washout/irrigation if appropriate
- the need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex.

Refer to the Marsden Manual for Clinical Procedures 6th Ed for the procedure guidelines when undertaking a DRE procedure

6. Allergy:

It is vital to check for allergies, including allergies to latex, soap (lanolin), peanut (present in arachas oil enema) and phosphate enema before undertaking these procedures.

7. When should nurses undertake manual removal of faeces:

- when other bowel emptying techniques have been unsuccessful
- faecal impaction/loading
- incomplete defecation
- inability to defecate
- neurogenic bowel dysfunction techniques are being developed
- in patients with spinal lesion

8. Sensitivities around these procedures
• DRE and manual removal of faeces are invasive procedures and should only be undertaken when necessary, and after individual assessment
• Cultural and religious beliefs need to be considered before undertaking these procedures
• In some circumstances, conflict between the patient or carer and nurse over the need for manual removal of faeces can create difficulties. In these circumstances, multidisciplinary consultation with colleagues is advised.
• To keep discomfort to a minimum when carrying out these procedures, ask the patient to lie on their left side if circumstances allow, and insert one lubricated finger only.
• Patient comfort may require the use of a commode/toilet

9. Spinal cord lesion and autonomic dysreflexia:

The National Patient Safety Agency identified several issues surrounding bowel care for people with a spinal cord lesion, especially when such individuals are admitted to general health care settings. In particular, health care staff need to recognise that a number of individuals with a spinal cord lesion and are dependent on manual evacuation as their established, routine method of bowel care. It must be recognised that these patients are experts in managing their bowel care. There is evidence to demonstrate that failing to support people with a spinal cord lesion who need a manual evacuation can place them at risk of developing autonomic dysreflexia. It can be harmful and even life threatening, to deviate from these patients’ routine method of bowel care, which will have been established with their specialist spinal injuries centre.

The patient, their carer or spinal injuries centre should be consulted if an alternative method of bowel care is being proposed. There can be serious implications if the bowel becomes distended due to constipation or impaction. This is one of the most common causes of autonomic dysreflexia (severe hypertension) amongst people with established spinal cord lesions. Autonomic dysreflexia usually occurs in people with a spinal cord lesion above the level of the sixth thoracic vertebra.

If left unresolved autonomic dysreflexia could have damaging outcomes such as cerebral haemorrhage, seizures and cardiac arrest.

10. Contra indications to the procedure:

The nurse should exercise particular caution when performing these procedures with patients who have the following diseases and or conditions:
• active inflammation of the bowel, including chrohn’s disease, ulcerative colitis and diverticulitis.
• recent radiotherapy to the pelvic area
• rectal/anal pain
• rectal surgery/trauma to the anal/rectal area
• tissue fragility due to age, radiation, loss of muscle tone in neurological diseases ormalnourishment
• obvious rectal bleeding
• known history of abuse
• spinal lesions due to the risk of autonomic dysreflexia
Presence of these contra indications would indicate that DRE or manual removal of faeces should not be undertaken until advice has been sought from a GP.

Once advice has been gained DRE or manual removal of faeces can be undertaken if the practitioner feels confident and is competent, to do so.

11. What to look for when observing the perineal and perianal area:

Prior to DRE or manual removal of faeces, abnormalities of the perineal and perianal area should be observed, documented and reported, the nurse must check for:

- rectal prolapse – degree, ulceration
- haemorrhoids – their number, position, grade, prolapse
- anal skin tags – number, position, condition
- wounds, dressings, discharge
- anal lesions (malignancy)
- gaping anus
- skin conditions - broken areas, pressure sores of all grades
- bleeding-colour of the blood
- faecal matter
- infestation
- foreign bodies

12. Other exclusions and contra-indications:

Nurses should not undertake DRE or manual removal of faeces when:

- consent – either written, verbal or implied has not been given
- the patient’s doctor has given specific instructions that these procedures are not to take place
- recent rectal/anal surgery or trauma
- The patient gains sexual satisfaction from these procedures and the nurse undertaking them finds this offensive, consultation with a doctor is advised, involving the patient in the consultation. The nurse might consider whether there is a need for a chaperone in some circumstances.

13. Manual removal of faeces as an acute intervention:

This should be undertaken following discussion with the GP

- Observations and risk factors

When using manual removal of faeces as an acute intervention, the procedure and approach differ from when using it as part of a regular package of care. While undertaking a manual removal of faeces as an acute intervention, observation must be made of:

- pulse at rest prior to the procedure
- pulse during the procedure
- blood pressure in patients with spinal lesions prior to, during and at the end of the procedure. a baseline blood pressure is advised for comparison
• signs and symptoms of autonomic dysreflexia – headache, flushing, sweating, hypertension
• distress, pain, discomfort
• bleeding
• collapse
• stool consistency


Observations and risk factors:

• distress, pain, discomfort
• bleeding
• Signs and symptoms of autonomic dysreflexia: headache, flushing, sweating, raised BP
• collapse
• stool consistency
**Procedural guidelines for the manual removal of faeces as a regular intervention**

**Equipment:**
- Disposable incontinent pad
- Adequate supply of disposable gloves (check if patient is allergic to latex)
- Disposable bag
- Lubricating gel

<table>
<thead>
<tr>
<th><strong>Action</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Explain the procedure to the patient. Check for allergies and if any adverse reactions have been experienced in the past. Obtain consent to the procedure.</td>
<td>The patient will be able to cooperate and feel comfortable this will aid the relaxation of the anal sphincter. Consent, either written verbal or implied needs to be obtained</td>
</tr>
<tr>
<td>Create privacy and position patient in the left lateral position with knees flexed in order to expose the anus</td>
<td>Maintain privacy and dignity allows easy insertion of a finger for removal of any faecal material</td>
</tr>
<tr>
<td>Place protective pad under patient, wash hands and put on gloves and apron</td>
<td>Protect bedding and minimize cross infection</td>
</tr>
<tr>
<td>Lubricate finger with gel. For patients who are undergoing manual removal for the first time apply anaesthetic gel to anus and allow manufacturers recommended time</td>
<td>To facilitate easier insertion of the finger and reduce discomfort</td>
</tr>
<tr>
<td>Tell the patient you are about to start the procedure and then insert gloved finger slowly into the patients rectum</td>
<td>To ensure patient is prepared and relaxed</td>
</tr>
<tr>
<td>a) In scybala-type stool, remove a lump at a time until no more faecal material can be felt</td>
<td>To minimise discomfort and make it easy to remove faecal material</td>
</tr>
<tr>
<td>b) In a solid mass, push finger into the middle of the mass and split it, remove small sections until no more faecal material can be felt. Extra lubrication may be required during the procedure</td>
<td></td>
</tr>
<tr>
<td>All faecal material should be put into an appropriate receptacle</td>
<td>To facilitate appropriate disposal of faecal material at the end of the procedure</td>
</tr>
</tbody>
</table>
Check patient is relaxed and comfortable during the procedure

When procedure complete wash and dry the patients buttocks and anal area and apply any cream if necessary

Put on clean gloves and remove the receptacle and dispose of its contents as per clinical waste policy

Remove gloves and apron and wash hands

Record findings in nursing documentation and communicate the results to patient/GP if required

Ensure Privacy & Dignity is maintained

To leave the patient in a comfortable and clean state

To minimize cross infection and correct disposal of bodily waste

To minimize cross infection

To ensure correct care is provided. To avoid duplication of care.

### 15. Rectal Irrigation:

Rectal irrigation will usually only be tried if other less invasive methods of bowel management have failed to adequately control constipation and/or faecal incontinence. Some patients may require additional supervision or monitoring until assessed that irrigation is not causing any problems. This may include:

- Spinal cord injury T6 and above ensure does not cause autonomic dysreflexia
- Unstable metabolic conditions
- Anorectal conditions that could cause pain or bleeding e.g haemorrhoids and anal fissures

**Contra-indications use only after discussion with the GP**

- Pregnant
- Active perianal sepsis
- Diarrhoea (available)
- Anal Fissure
- Haemorrhoids
- Faecal impaction
- Past pelvic radiotherapy
- Known severe diverticular disease
- Use of rectal medications for other diseases
- Congestive cardiac failure
- Anal surgery within the past 6 months
- Acute inflammatory bowel disease
- Known obstructing rectal or colonic mass
- Severe cognitive impairment (unless carer available)
# Procedure Guidelines for Rectal Irrigation

The procedure will normally take place while sitting on a toilet or commode

## Equipment:

- **Irrigation Bag**
- **Control unit**
- **Single use rectal catheter**
- **Disposable gloves/Apron**
- **Skin cleaning wipes**

## Action | Rationale
--- | ---
Gain Consent | To ensure patient has full understanding and engagement with the procedure
Ensure Privacy and Dignity | Patient will feel more comfortable and relax
Fill the bag full to the marker with Lukewarm tap water | Ensures the system works efficiently and makes it easier to control how much water is inserted
Assemble the equipment connect the irrigation bag, control unit and single-use rectal catheter blue to blue and grey to grey | Ensures the user has full control of the equipment
Strap pump to leg if this is more convenient | May assist in the procedure for some people
Document all procedures in patients notes | |
Open the catheter and turn the control knob to the water symbol | |
Pump the control unit 2-3 times | This will prime the tubing with water and activate the self lubricating coating on the catheter
Turn the control knob to the balloon symbol | |
Using NO force gently insert the catheter into the anus | |
Holding the catheter in place pump the balloon 3-4 times this will hold the | |
catheter in place

Turn the control knob to the water symbol and start to pump water into the rectum about 1 pump every 2 seconds, **slower for spinal injury may be required.**

When finished turn the knob to the air symbol to deflate the balloon and remove the catheter

Clean and dry patient and remove waste in line with trust policy

Document the procedure in patients notes

| Assist with patient comfort | Ensures good record keeping and communication |

16. **Digital stimulation:**

In patients with an upper motor neurone spinal cord lesion a reflex bowel should be present.
Stimulation of the anus or anal sphincter can aid some patients with defaecation. The procedure can be performed by a nurse or the patient/carer can be taught to do this.

17. **Treatment of Constipation:**

Constipation is not a disease but a symptom of an underlying condition. Some causes of constipation can be simply resolved with adjustments to certain aspects of the individual’s lifestyle, such as change of diet, increased fluid intake and improved exercise.
However, other causes are more complex. Community healthcare practitioners commonly encounter patients with constipation and it is not uncommon for the nurse to be the key person who will assess, treat and manage this condition.
Practitioners key aims should be to improve the management of constipation, and provide patients with the appropriate advice and information about their symptoms and treatment to prevent further episodes of constipation.
DRE and manual removal of faeces should not be seen as a first line investigation in the assessment and treatment of constipation

If patient presents with constipation

**Complete the Bexley Care Trust bowel dysfunction assessment form (Appendix 2)**

If history or examination suggests;
- Rectal bleeding or malaena stool
- Active inflammatory bowel disease
- Unexplained weight loss
- Excessive abdominal tenderness and or distension
- Paryletic ileus
- Recent radiotherapy or extensive surgery to the pelvic area
- Rectal/anal pain
• Patient with a history of abuse
• Patient with known allergies, e.g. Arachis oil, Latex
• Abdominal pain and/or continual bloating

Do not go ahead with any treatment and refer patient to the GP for further investigation or advice

If none of the above are present continue with the examination and assessment.

• Explain and discuss the procedure with the patient to ensure that the patient understands the procedure and gives his/her consent.

• Ensure privacy.

• Allow patient to empty their bladder first if necessary.

• Observe abdomen for any distension or abnormalities.

• Feel abdomen to ensure abdomen is soft, not excessively tender on palpation and no masses other than faecal can be felt.

• Listen with a stethoscope for bowel sounds. If on examination, faeces is felt in the rectum, the nurse will use her professional judgment to decide:

Whether a change in diet, increase in fluid intake and improved exercise will be appropriate first line management for the patients symptoms and reassessment will be arranged within 48 hours. Whether a change in diet, increase in fluid intake and improved exercise and/or a laxative is likely to resolve the problem therefore an appropriate laxative will be prescribed and reassessment will be arranged within 48 hours. Whether if the patient is severely constipated an enema or suppositories will be prescribed and treatment carried out as planned by the nurse to resolve the patients immediate symptoms. Reassessment will be arranged in 4-7 days and patient education will be given to try to prevent the symptoms reoccurring. All patient examination findings and treatment prescribed should be documented in the patients nursing and medical notes according to trust guidance

Prescribing rectal medication:

Community Specialist Practitioners prescribe independently from the nurses formulary and a number of nurses are now independent prescribers this allows the supply and administration of prescription only medicines by nurses, without the need for prior consultation with and prescription from a GP. Nurses not holding these qualifications will need to liaise with GP or Nurse Prescriber to obtain prescriptions before carrying out procedure

Medicines for the relief of constipation:

Oral laxatives, or when this has not produced a bowel movement or rapid relief from rectal loading a suppository or enema may be required. For the procedure guidelines for the administration of enemas or suppositories see the Marsden Manual 6th Ed
Nurses administering medicines, as part of their practice should have a sound knowledge and understanding of the medication, indication for use side effects and contra indications, irrespective of whether they have the legal right to prescribe them.  

**For side effects of all prescribable preparations please refer to the NPF/BNF**

### 17. Faecal Incontinence:

Faecal incontinence is a sign or a symptom not a diagnosis. Between 1% and 10% of adults are affected with faecal incontinence, with 0.5-1.0% of adults experiencing regular faecal incontinence that affects their quality of life.

A detailed initial assessment and structured approach to management are needed starting with addressing reversible factors and, only if this fails to restore continence, progressing to specialized options and investigations.

Treatment and care should take into account individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow people to reach informed decisions about their care. (NICE June 2007)
References

Process for the Delegation of Tasks June 2003 SLPCT

MDA DB 9601 Latex sensitisation in health care settings. London: Medical Devices Agency
National Patient Safety Information September 2004
Nice Guidance

National Institute for Health and Clinical Excellence (2007)
Faecal incontinence The management of faecal incontinence in adults (NICE,2007)

Poulton B, Thomas S (1999) The nursing cost of constipation: Clinical update Primary Health Care
November 9(9): 17-22

Further reading
Royal Marsden Hospital, manual of Clinical Nursing procedures 6th edition June 2004
"Abdominal massage can be helpful in chronic constipation FACT (Focus on alternative and complementary therapies) September 1998; 3(3): 122-123
Medicines Resources Centre “The management of constipation” MeReC Bulletin 1999. 10(9): 17-22
RCN Continuing Education 'Faecal incontinence in adults' Article 620

Useful Contact
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD
Tel: 020 7927 9500
Web site: www.npsa.nhs.uk
Bowel Management Competencies

**INTRODUCTION**

This competence covers the procedure for digital rectal examination (DRE) and manual removal of faeces (MRF).

It is to be used following theoretical input provided by the Trust. You may require up to three assessments before you are deemed competent to perform this procedure.

**KSF Dimension & Level**

Health and wellbeing HWB7: Interventions and treatments  
Level 3: Plan, deliver and evaluate interventions and/or treatments

The following policies need to be read in conjunction with the competencies:

- Bowel Management policy
- Infection control policy
- Medicines management policy
- Marsden Manual clinical nursing procedures 6th Ed
# Bowel Management Competencies

Name…………………………………………

<table>
<thead>
<tr>
<th>COMPETENCY</th>
<th>OUTCOME</th>
<th>DATE ASSESSED/ACHIEVED</th>
<th>DATE ASSESSED/ACHIEVED</th>
<th>PRACTITIONER/ASSESSORS SIGNATURE</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| HAS UNDERTAKEN MANDATORY TRAINING | • Provides evidence of training  
• Has been assessed as competent to practice  
• Knows when not to undertake procedure  
• Able to recognise when relevant to refer on | | | | |
| COMMUNICATION/DOCUMENTATION; Communicates with patient and family to gain trust and reduce anxiety | • Demonstrates ability to gain patient/carer trust whilst communicating need for procedure and gains consent to proceed  
• Informs the patient about the implications of the procedure | | | | |
<table>
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<tr>
<th><strong>ENSURES CONSENT IS OBTAINED;</strong></th>
<th>• Able to demonstrate knowledge to inform consent process</th>
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| **ESTABLISHES MULTI PROFESSIONAL / AGENCY WORKING WHERE APPROPRIATE;** | • Discusses with the multi-professional team when necessary  
• Documents communication with the multi-professional team and therapeutic decisions |
| **CARRIES OUT THE PROCEDURE IN LINE WITH TRUST POLICY OR MARSDEN MANUAL GUIDELINES;** | • Identifies and discusses all contraindications to the procedure  
• Supports patient throughout the procedure  
• The procedure is carried out safely and effectively in line with policy  
• Addressed patients privacy and dignity throughout the procedure |
| **INFECTION CONTROL;** | • Demonstrates appropriate infection control technique  
• Demonstrates good clinical waste procedure |
| **CORRECTLY DOCUMENTS ALL INTERVENTIONS/PROCEDURES INTO NUSING AND MEDICAL NOTES;** | • Demonstrates correct record keeping  
• Writes appropriate care plans |
<table>
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<tr>
<th>GOVERNANCE / RISK</th>
<th>- Documents batch numbers and expiry dates where appropriate</th>
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<td>- Demonstrates a sound knowledge of Trust policy</td>
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<td></td>
<td>- Highlights risks associated to the procedure</td>
</tr>
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<td></td>
<td>- Identifies when to refer on</td>
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</tbody>
</table>
Patient’s Name................................................. Date of Birth........................................

Name of Assessor..............................Designation... Date of Assessment..............

**Patient’s/Carer’s Perception**

<table>
<thead>
<tr>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fluid Intake in 24 hours (cups and type)..............................................................................................................</td>
</tr>
<tr>
<td>Dietary Intake: Yes □ No .................................................................................................................................</td>
</tr>
<tr>
<td>High Fibre Yes □ No .................................................................................................................................</td>
</tr>
<tr>
<td>Low Fibre Yes □ No .................................................................................................................................</td>
</tr>
<tr>
<td>Enteral Feeding Yes □ No ............................................................................................................................</td>
</tr>
<tr>
<td>Special Diet Yes □ No .....................................................................................................................................</td>
</tr>
<tr>
<td>Known to Dietician Yes □ No ............................................................................................................................</td>
</tr>
</tbody>
</table>

1. Are there any problems related to dietary intake or digestion? ie, weight loss, vomiting, anorexia, sore mouth, ill-fitting dentures, swallowing difficulties, food allergies:

...........................................................................................................................................................................

2. Since your bowel habit has changed have you had any new medication? If yes, give details:

...........................................................................................................................................................................

**Medications:**
ie Antibiotics, Analgesia, Iron ...............................................Oral/Rectal

3. Do you smoke?  Yes □  No     If yes how many a day............

4. Do you drink alcohol?  Yes □  No  If yes, Number of units daily............

5. What physical activities do you undertake?  None? ........
   Walking? ...............  Swimming? ...........................  Gardening?

6. Has any member of your family ever had any problems with their bowels?  Yes □  No
   If yes, please give details..................................................................................

7. How do you manage your problem?  (Bulking agents used?)..........................

8. Do you use laxatives?  Yes □  No
   If yes, what do you take and how long have you been taking them?  .................

9. Do you ever have to use assistance eg Finger to remove the stool?  Yes □  No
   If yes, please give details..................................................................................

**Relevant Surgery/Diagnosis:**

- Autonomic dysreflexia  Yes □  No  Diverticulitis  Yes □  No □
- Crohns/ulcerative colitis  Yes □  No  Bowel Resection  Yes □  No □
- Irritable Bowel Syndrome  Yes □  No  Hiatus Hernia  Yes □  No □
- Coeliace Disease  Yes □  No  Bowel Tumour  Yes □  No □
- Reconstructive Surgery  Yes □  No  Rectal Prolapse  Yes □  No □
- Haemorrhoidectomy  Yes □  No  Radio/Chemotherapy  Yes □  No □
- Anal Sphincter Injury  Yes □  No  Aids/HIV  Yes □  No □
- Childbirth Trauma  Yes □  No  Learning Disability  Yes □  No □
- Non-Bowel Trauma  Yes □  No  Spinal Injury  Yes □  No □
- Neurological Problems  Yes □  No  If yes, type of diabetes
   Yes  If yes, give details

**SYMPTOMS**

1. What is your normal defecation pattern? .........................................................
2. Are you aware of the need to defecate? Yes □ No □
   Is there any urgency? Yes □ No □
   Did you have a normal routine? eg, time of day/frequency Yes □ No □
   Do you have to return to the toilet shortly after defecation? Yes □ No □
   If yes, do your bowels open again? Yes □ No □
3. Is the faecal matter difficult to pass? Yes □ No □
   If yes, state reason/symptoms…………………………………………………………...
   ……………………………………………………………………………………………
4. Do you know when you want to pass flatus? Yes □ No □
   Can you control it? Yes □ No □
5. Do you experience staining associated with flatus? Yes □ No □
6. Can you manage to clean yourself after having your bowels open? Yes □ No □
   What do you use to wipe yourself? …………………………………………………
7. Have you had any recent change in bowel habit? Yes □ No □
   If yes, please give details ………………………………………………………………

**FAECAL INCONTINENCE**

1. How long have you had this problem? ……………………………. Is it: Better / Worse / Same

2. Is the faecal incontinence related to certain times or particular incidents? Yes □ No □
3. During the episode of faecal incontinence do you experience any medical symptoms? ie, rectal bleeding, tachycardia pain, etc.

If “Yes” please comment …………………………………………………………………………

4. Have you had staining on your underclothes?

Yes □    No □

5. During the episode of incontinence what is the colour and smell of the stool?

   Colour…………………………………………………………………………

   Bristol Stool Form Type…………………………………………………………

   Any abnormal smell? ……………………………………………………………

6. Is there mucus?

Yes □    No □

7. Is there blood?

   If yes, is it:

   Fresh   Yes □    No □    On the toilet seat   Yes □    No □
   Black   Yes □    No □    In the stool        Yes □    No □
   On the paper Yes □    No □    Following the stool Yes □    No □

---

**ENVIRONMENT**

1. Is the height of the toilet satisfactory?

Yes □    No □

2. Do your feet rest on the:

   Floor □    Box □

3. Do you have privacy (ie Do doors have locks)?

Yes □    No □

4. Do you have adequate time?

Yes □    No □

5. Is the toilet accessible?

Yes □    No □

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**EFFECTS ON LIFESTYLE**

Are there any communication problems?

Yes □    No □

ow does the client communicate the need to go to the toilet? ……………………………
………………………………………………………………………………………………

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**PHYSICAL EXAMINATION**
Bowel sounds listened to
Yes □  No □

Digital Rectal Examination to identify contents of rectum- using Bristol Stool Form Scale ...

Verbal consent obtained
Yes □  No □

Visible Rectal Prolapse  Yes □  No □  Excoriation of Skin  Yes □  No □

Gaping Anus  Yes □  No □  Anal Sphincter Tone  Present/Not Present

Piles  Yes □  No □  Skin tags  Yes □  No □

If history or examination suggests:

(a) Rectal bleeding or malaena stool.

(b) Active inflammatory bowel disease.

(c) Unexplained weight loss.

(d) Excessive abdominal tenderness and or distension

(e) Paryletic ileus.

(f) Recent radiotherapy or extensive surgery to the pelvic area.

(g) Rectal/anal pain.

(h) Patients with a history of abuse.

(i) Patients with known allergies, eg Arachis Oil, Latex.

(j) Abdominal pain and/or continual bloating.

Do not go ahead with any treatment and refer patient to the G.P for further investigation or advice.

Goals of care ........................................................................................................
...........................................................................................................................
...........................................................................................................................

Aids/Appliances □  Medication review □

Treatment for Constipation □  Management of Faecal Incontinence □

Management of Diarrhoea □  Pelvic Floor Exercises □
Exercise programme: Activity □ GP for further advice/investigations/referral □

Review Date & By Whom …………………………………………………………………………

DN/GP to be informed of assessment details……………………………………

Date……………….

Signature of Assessor ………………..Designation…………….Date………………

**NB:** Bowel dysfunction due to constipation should be investigated and treated in accordance with Trust policy. Faecal incontinence is a symptom and requires investigation to ascertain the cause so that appropriate treatment can be instigated. ( Faecal Incontinence ( NIHCE 2007 )
Developed by Heaton and Lewis at the University of Bristol